MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 516 a

07139

CERTIFICATE OF DEATH

Reg. Diat. No. 2/2

1. PLACE OF DEATH:
County Montgomery
City or town Dawsonville, Boyds R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 81 yrs
Hospital, institution, or street address where death occurred

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Montgomery
City or town Dawsonville (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No. P.O. Boyds Md
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Robert Wilkuson Allnutt

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Alice Allnutt
6.(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) April 12 - 1866

8. AGE: Years 81 | Months 6 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Dawsonville, Montg. Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
12. FATHER Name Benonie Allnutt
13. Birthplace Md
14. MOTHER Maiden name Emily Dawson
15. Birthplace Md
16. Informant Mrs Alice Allnutt
Address Boyd, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29-47 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville Md
18. Funeral director Williams & Hilton
Address Barnesville Md

19. Aug 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27th 1947 at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1941 to Aug 27th 1947 and that I last saw him alive on Aug 27th 1947

	DURATION
Immediate cause of death Carcenomata of prostate.	6 yrs.
Due to ? Asthenia & Gradual failure of all the functions	2 Mos.
Due to Physical existence of Myocardial disease.	3 Wks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Walter N. Mouse M.D. M. D. or Other
Address P.O. Boyds - Dawsonville Md Date signed 8/27/47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07140

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Calvert

City or town: North Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: 2WW

3.(a) FULL NAME: AMBERG, Edward Melvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Betty Amberg

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 March 1920

8. AGE: Years	Months	Days	If less than one day
27	5	11	hrs. min.

9. Birthplace: Minn. (Town, county, and state)

10. Usual occupation: Mech. Md.

11. Industry or business: Naval Research Lab., North Beach

FATHER
12. Name: AMBERG, Otto dec.
13. Birthplace: Finland

MOTHER
14. Maiden name: TUMBERG, Ida dec.
15. Birthplace: Minn.

16. Informant: wife: Mrs. Betty Amberg
Address: North Beach, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-16-47 (month) (day) (year)

Cemetery or crematory: Woodland

Location: New York Mills, Minn.

18. Funeral director: W. W. CHAMBERS & Son.
Address: 517 11th St., S.E., Wash., D.C.

19. 8-12 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 August 1947 at 9:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 July 1947 to 12 August 1947 and that I last saw him alive on 12 August 1947

Immediate cause of death: Subarachnoid hemorrhage, Repeated also intraventricular hemorrhage — DURATION: 2 mos.

Due to: Essential Hypertension — 3 yrs. 4 years

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: Bilateral burr hole in skull found intraventricular hemor. Date of op. 8-5-47

Autopsy results: Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. C. Messerschmidt H. C. MESSERSCHMIDT, Lt. (jg) (MC) USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-12-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46d 1

07141

Reg. Dist. No. 214

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ——

Hospital, Institution, or street address where death occurred:

8502 Georgia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)

Street No. 8502 Georgia Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JOHN A. ANDREAS

3.(b) Social Security Number 214-03-8157

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife Clara Andreas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1876

8. AGE: Years	Months	Days	If less than one day
70	10	23	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Retired butcher

11. Industry or business

FATHER 12. Name John A. Andreas

13. Birthplace Germany

MOTHER 14. Maiden name Rosa Theophel

15. Birthplace Germany

16. Informant Mrs. Clara Andreas

Address 8502 Ga. Ave., Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 19, 1947 (month) (day) (year)

Cemetery ~~xxxxxx~~ Prospect Hill Cemetery

Location Washington, D. C.

18. Funeral director Waxnax E. Pumphrey

Address Silver Spring, Md.

19. Aug 18 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 19 47 at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-7-45 19 to 8-16-47 19 and that I last saw him alive on August 16th 19 47

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	2 days
Due to Hypertension and generalized arteriosclerosis	5 yrs.
Due to Left hemiplegia	2 yrs.
Other conditions Carcinoma of rectum	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations No operations. Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Schoemaker M. D. or other

Address 8005 Woodbury Dr., S.S., Md. Date signed 8/16/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 214 — 07142

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring, Md. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/13/46 - 8/8/47

Hospital, institution, or street address where death occurred:

How long in hospital or institution? Jan. 13, 1946 - Aug. 8, 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D.C. County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Shoreham Hotel
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lucretia E. (Kingston) Ash

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 26, 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
79	10	18		

9. Birthplace: Buffalo, New York
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: JOHN ROBERT KINGSTON ~~Murphy~~
13. Birthplace: ROME, N.Y.

MOTHER
14. Maiden name: ~~E. Murphy~~ Kingston
15. Birthplace: IRELAND E. Murphy

16. Informant: CEDARCROFT SANATORIUM
Address: SILVER SPRING - (Rural)

17. (Burial, cremation, or removal. Which?) Removal Date thereof: (month) Aug. 8, (day) (year) 1947

Cemetery or crematory: Rock Creek Cemetery

Location: Wash. D.C.

18. Funeral director: Martin W. Hysong Co.

Address: 1300 N St., N.W. - WASH., D.C.

19. (Date rec'd by registrar) Aug 8 1947 Registrar: Josephine M. Schaaff

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8, 1947 19 8 at AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 13, 1946 19 to August 7, 1947 and that I last saw her alive on August 7, 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 year
Due to: Cerebral Arteriosclerosis	6 mos. 26 ds.
Due to: Chronic Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Richard B. Hibbard M.D.
M. D. or other

Address: Cedarcroft Sanitarium Date signed: 8/8-47

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83b

07143

Reg. Dist. No. 216

FILM No. G 112 AUG 25 1947

1. PLACE OF DEATH:

County MONTGOMERY

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Magnolia Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Barbara A. Bagnam

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1854

8. AGE: Years	Months	Days	If less than one day
92 ~~95~~			hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name William Arnold

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Phillip C. Arth

Address 2 Magnolia Parkway

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Congressional

Location Washington, D. C.

18. Funeral director The S. H. Hines Company

Address 2901 14th St. N. W. Wash. D. C.

19. 8/11 1947 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1947 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 24 1947, to Aug 11 1947 and that I last saw h.. alive on August 10 1947

Immediate cause of death	DURATION
Cerebral Thrombosis	18 days
Due to Generalized Arteriosclerosis	?
Due to	
Other conditions None	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E Herbert Bauersfeld M.D.
M. D. or other

Address 1912 R St. N.W. Date signed 8/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

07144

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:
County Montg
City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 yrs
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg.
City or town Dickerson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Katherine Virginia Baker

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Walter R Baker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 21 - 1877

8. AGE:	Years	Months	Days	If less than one day
	69	9	19	..... hrs. ..... min.

9. Birthplace Leesburg, Virginia
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Curtis Compher
13. Birthplace Virginia
MOTHER 14. Maiden name Henrietta Harper
15. Birthplace Virginia
16. Informant Henry Baker
Address Dickerson, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12-47 (month) (day) (year)
Cemetery or crematory Monocacy
Location Beallsville Md
18. Funeral director William B Hilton
Address Barnesville Md
19. 8/11/47 19..... Mrs. C. C. Hilton By Mrs. W.B.H. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10-1947, at 4.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 8 - 1947, to Aug. 10 - 1947
and that I last saw her alive on August 10 - 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Byron S. White, Md. M. D. or other
Address Poolesville, Md. Date signed 8/11/47

VS A15

(1) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07145

169 M

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Monty

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred:
Off Capitol Views Rd.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D C County: D. C.

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2633 Whitby Place N.W
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME George A. Ballard

3.(b) Social Security Number 578-03-8139

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude J. Ballard

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 1, 1915

8. AGE: Years	Months	Days	If less than one day
32	5	16	..... hrs. ..... min.

9. Birthplace: Orange County, Virginia
(Town, county, and state)

10. Usual occupation: Fed. Works Agency-Detective

11. Industry or business: Fed. Works Agency

FATHER
12. Name: Thomas A. Ballard
13. Birthplace: England

MOTHER
14. Maiden name: Lillie Garrett
15. Birthplace: Orange County, Virginia

16. Informant: Charles W. Ballard
Address: 2828 31st, SE, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 23, 1947 (month) (day) (year)

Cemetery or crematory: Ft. Lincoln Cemetery

Location: District Line, D.C.

18. Funeral director: W. Reuben Humphrey

Address: Bethesda, Maryland

19. 8/22/1947 (Date rec'd by registrar) Wm E Jules Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18, 1947 at ? P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19.. to Aug 19..
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Carbon Monoxide Poisoning	Instantaneous
Due to: Suicide	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 8-17-47
Where did injury occur? Kensington (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bosshart M.D. Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md. Date signed: 8-21-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

COPY

07146

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos 1 day

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 6 mos 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Louisiana County:

City or town: New Orleans

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Metairia Lawn

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I & II

3.(a) FULL NAME: BENNETT, Arthur Ray

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Clara Bennett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1 July 1889

8. AGE: Years	Months	Days	If less than one day
58	1	13	hrs. min.

9. Birthplace: Kentucky (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: U. S. Navy

FATHER 12. Name: Samuel Bennett

13. Birthplace: Kentucky, deceased

MOTHER 14. Maiden name: Oma Schultz

15. Birthplace: Kentucky, deceased

16. Informant: Wife: Mrs. Clara Bennett

Address: 223 Metairia Lawn, New Orleans, La.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 8-14-47 (month) (day) (year)

Cemetery or crematory: New Orleans, Louisiana

Location: New Orleans, Lousiana

18. Funeral director: Wm. Reuben Pumphrey

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 8-14- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 August 19 47 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-13- 19 47 to 8-14- 19 47 and that I last saw him alive on 8-14- 19 47

Immediate cause of death	DURATION
Multiple myeloma	1 yr ?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. D. CONLIN, LTJG MCR USNR (M. D. or other)

Address: USNH, Bethesda, Md. Date signed: 8-14-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/24/47

07147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 928

CERTIFICATE OF DEATH

Reg. Dist. No. 213

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Rural - Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural - Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D - Gaithersburg
(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Henry Bradley Bohrer

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Alice May Robertson Bohrer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 17-1865

8. AGE: Years	Months	Days	If less than one day
81	11	10	..... hrs. ..... min.

9. Birthplace Bethesda - Montg. Co. - Md.
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John Bohrer

13. Birthplace Baltimore Maryland

MOTHER 14. Maiden name Elizabeth Rinehart

15. Birthplace Pennsylvania

16. Informant Elizabeth A. Bohrer - Daughter

Address R F D - Gaithersburg - Maryland

17. Burial Date thereof Aug 30/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rockville Union Cem.

Location Nr - Rockville - Maryland

18. Funeral director Wm. Reuben Plumbery

Address Rockville - Maryland

19. 8-29 1947 E P Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1947, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 5 1947, to Aug. 27 1947

and that I last saw him alive on August 26, 1947

Immediate cause of death	DURATION
Cerebral apoplexy	4 days
Due to arterio sclerosis	
Due to	
Other conditions Chronic valvular heart disease. (Include pregnancy within 3 months of death)	

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G. O. Hartley M. D. - M. D. or other

Address Rockville, Md Date signed 8/29/47

07149

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Maryland
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: BOWDEN, Ray William

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 January 1892

8. AGE: Years	Months	Days	If less than one day
55	7	0	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: William R. Bowden
13. Birthplace: England

MOTHER
14. Maiden name: Hanah Hughes
15. Birthplace: New York

16. Informant: Daughter; Mrs. Mary B. Denny
Address: 16 Burns St., NE, Washington, D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-25-47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Maryland

18. Funeral director: W. W. Chambers Co. E.L.J.
Address: 517 11th St., SE, Washington, D.C.

19. 8-24 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 August 1947 at 10:05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 August 1947 to 23 August 1947 and that I last saw him alive on 23 August 1947

Immediate cause of death	DURATION
Bronchogenic Carcinoma with Metastases to Lymphatics, Liver, Adrenals and Bone.	
Due to:	
Due to:	
Other conditions: Diabetes Mellitus.	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Same as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, LTJG MC USNR M. D. or other
Address: USNH, Bethesda, Md. Date signed: 8-24-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cost of this is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/27/47 T

07148

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13b

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural) (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State N.Y. County
City or town Rochelle (If outside city or town limits, write RURAL and give nearest town)
Street No. 50 Glen Car Avenue (If rural, give LOCATION)
2.(a) If veteran, name war WWI

3. (a) FULL NAME BOXBERGER, George "J"

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) 26 February 1891

8. AGE: Years	Months	Days	If less than one day
56	5	28	... hrs. ... min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual occupation unknown
11. Industry or business

FATHER
12. Name BOXBERGER, George dec.
13. Birthplace N.Y.

MOTHER
14. Maiden name LWOSE, Margaret dec.
15. Birthplace Germany

16. Informant sister: Mrs. Jeannette Cooper
Address 50 Glen Car Avenue, New Rochelle, N.Y.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-26-47 (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director W. W. CHAMBERS RWB
Address 3072 M St., N.W., Wash. D.C.

19. 8-25- 19 47 Mary Charlotte Smith Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 August 19 47, at 5:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 August 19 47, to 24 August 19 47
and that I last saw him alive on 24 Aug 19 47

Immediate cause of death: Pulmonary Reinfection active, far advanced — DURATION: und

Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE C. H. C. SMITH, Cdr. MC USN
M. D. or other
Address USNH Bethesda, Md. Date signed 8-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

8/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195d (1498)

67150

CERTIFICATE OF DEATH

Reg. Diat. No. 217

M

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. R # 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Dorothy Kimball Bryan

3.(b) Social Security Number 219-12-4421

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Mr. Francis T. Bryan

6.(c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) December 24, 1923

8. AGE: Years 23 | Months 7 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER 12. Name George Kimball

13. Birthplace Arlington, Va.

MOTHER 14. Maiden name Mary Knight

15. Birthplace Rockville, Maryland.

16. Informant Hospital records

Address

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUG 17 1947 (month) (day) (year)

Cemetery ~~or crematory~~ BURTONSVILLE UNION

Location BURTONSVILLE MONTG. CO. MD

18. Funeral director Warner E. Pumphrey

Address SILVER SPRING, MD.

19. 8-16- 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947, at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/14/47 1947, to 8/15/47 1947 and that I last saw h[er] alive on 8/14/47 1947

Immediate cause of death	DURATION
Asphyxiation	
Due to Aspiration of Food into Bronchi during	
Due to Extra-uterine pregnancy	3 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Left tubal abortion

Date of op.

Autopsy results Not in Hospital

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 8/16/47

VS A15 9-45-15M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07151

1318

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Norbeck

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs.

Hospital, Institution, or street address where death occurred:

None

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Norbeck

(If outside city or town limits, write RURAL and give nearest town)

Street No.: None

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish-American

3. (a) FULL NAME: LYNN M. CAMPBELL

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laura Clark Campbell

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 9, 1869

8. AGE:

Years	Months	Days	If less than one day
78	2	27	..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Pullman Company

FATHER — 12. Name: John B. H. Campbell

13. Birthplace: Montgomery County, Md.

MOTHER — 14. Maiden name: Ellen Magruder

15. Birthplace: Maryland

16. Informant: Laura C. Campbell

Address: Norbeck, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5, 1947 (month) (day) (year)

Cemetery or crematory: St. Marks Prot. Epis. Ch. Cem

Location: Highland, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Bethesda, Maryland

19. 8-6 1947 (Date rec'd by registrar) E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5, 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24 1947 to Aug 5 1947 and that I last saw him alive on Aug 5th 1947

Immediate cause of death	DURATION
Uraemia	Unknown
Due to: Chronic Nephritis	4
Due to: Cause Unknown	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Vernon H. Dyson M. D. or other

Address: Laytonsville Md. Date signed: Aug 6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124a 9

07152

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 21 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: N.J. County:
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 Bellgrove Drive
(If rural, give LOCATION)
2.(a) If veteran, name war: WWI

3.(a) FULL NAME: CARLTON, Granville, Michaux

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9 December 1888

8. AGE: Years	Months	Days	If less than one day
58	8	0	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Chief Clerk, General Accounting
11. Industry or business: Government

FATHER
12. Name: CARLTON, Granville dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: WILKENSON, Ida dec.
15. Birthplace: Va.

16. Informant: sister: Mrs. Louise Bateman
Address: 410 Bellgrove Drive, Arlington, N.J.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-13-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.

19. 8-10 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 August 1947 at 7:22 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 May 1947 to 9 August 1947 and that I last saw him alive on 9 August 1947

Immediate cause of death	DURATION
MULTIPLE SEPTIC LUNG ABSCESSES	2 Mos.
Due to	
Due to	
Other conditions: PRIMARY LAENNEC'S CIRRHOSIS (Include pregnancy within 3 months of death)	6 Mos.

Major findings of operations:
Date of op.:
Autopsy results: (SAME AS ABOVE)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan
J. B. BRYAN, Lt.(jg) (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 8-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

8/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

07153

CERTIFICATE OF DEATH

Reg. Dist. No. 717

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-151

1. PLACE OF DEATH:
County Montgomery Co
City or town Silver Springs Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
708 - Sligo Ave
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2236 - Chester St, S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Charity Cator

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	widowed

6.(b) Name of husband or wife William Cator
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15 - 1874

8. AGE: Years 72 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Silver Hill, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name J. Clifton
13. Birthplace Ky

MOTHER 14. Maiden name Elizabeth Clifton
15. Birthplace Md

16. Informant Edward Cator
Address 117 - 36 St. N E

17. removal (Burial, cremation, or removal. Which?) Date thereof Aug 13 - 47 (month) (day) (year)

Cemetery or crematory
Location

18. Funeral director Arthur E. Simmons Jr
Address 2007 - Nichols Ave SE

19. Aug 13 19 47 (Date rec'd by registrar) Josephine M. Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13, 1947 (m.) ..... (d.) ..... at 1:45 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 4 19 47 to Aug 13 19 47 and that I last saw her alive on Aug 13 19 47

Immediate cause of death	DURATION
Cerebral hemorrhage	1 wk.
Due to Generalized arteriosclerosis	years.
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE C P Ryland M. D. or other
Address 1901 Mass Ave NW Date signed 8-13-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07154

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For unborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R # 3. Norbeck.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edna Claggett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Married

6.(b) Name of husband or wife: Allison Claggett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 24, 1923

8. AGE: Years: 24 | Months: 1 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Howard Thomas
13. Birthplace: Montg. Co. Maryland

MOTHER
14. Maiden name: Bessie Cook
15. Birthplace: Montgomery Co. Maryland

16. Informant: Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 22, 1947 (month) (day) (year)

Cemetery or crematory: Sandy Spring

Location: Sandy Spring, Md.

18. Funeral director: R. L. Snyder

Address: 246 N. Washington St, Rockville

19. 8-20- 1947 (Date rec'd by registrar) Gertrude B. Lawson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 — 1947, at 1:59 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 — 1947 to 8-19 1947 and that I last saw her alive on 8-19-47 1947

Immediate cause of death	DURATION
Tuberculosis of adrenal glands	4 wks
Due to: General Tuberculosis	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas B Tyneblason M. D. or other

Address: Sandy Spring Md. Date signed: 8-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67155

92d

Reg. Diat. No. 218

1. PLACE OF DEATH: Montg, Co,

County

City or town Germantown, Md, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Yr 6 Mo,

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residsnee of mother)

State County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Clara Louise Clements,

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept 16th 1858

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
1858 88	10	20		

9. Birthplace: Barnsville Md
(Town, county, and atate)

10. Usual occupation: House Keeping

11. Industry or business

FATHER
12. Name: Peter Henry Clements
13. Birthplace: Md,

MOTHER
14. Maiden name: Mary Ellen Bell
15. Birthplace: Md.

16. Informant: Mrs William C. Cloyd
Address: Germantown. Md,

17. Burial (Burial, eremation, or removal. Which?) Date thereof 8/9/47 (month) (day) (year)
Cemetery or crematory: St Marys Cemetery
Location: Barnsville, Md,

18. Funeral director: ERNEST C, GARTNER
Address: Gaithersburg Md,

19. Aug 8 1947 (Date reg'd by registrar) Abraham G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6th 1947 at 1-40PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947 to Aug 6 1947 and that I last saw her alive on Aug 6 1947

	DURATION
Immediate cause of death: Agnity Congestive Heart failure	2 days
Due to: Chronic valvular Heart disease	several years
Due to:	
Other conditions: arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findiogs of operatioos

Date of op.

Aotopsy resolts

PHYSICIAN: Please underline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due fo external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Masns of Injury Injured at work?

23. SIGNATURE: G. V. Hartley, M.D. M. D. or other

Address: Rockville, Md Date signed 8/7/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10 2

07157

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County MONTGOMERY
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital 8600 Old Georgetown Rd.
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8560 Georgia Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Crismond, Mary A

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~ Henry W. Crismond deceased. 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 2, 1859

8. AGE: Years	Months	Days	If less than one day
88	5	14	..... hrs. ..... min.

9. Birthplace Knoxville, Tenn.
(Town, county, and state)

10. Usual occupation Home Maker

11. Industry or business

FATHER 12. Name Henry Peacock
13. Birthplace Virginia

MOTHER 14. Maiden name Mary Ruddy
15. Birthplace Virginia

16. Informant Miss Isabel Crismond
Address 8560 Georgia Ave., S.S., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 20, 1947 (month) (day) (year)
Cemetery ~~or crematory~~ Union
Location Leesburg, Va.

18. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. 8/18 1947 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH ~~March~~ August 17, 1947, at 3:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 12, 1947, to Aug. 17, 1947 and that I last saw her alive on Aug. 16, 1947

Immediate cause of death	Cardiac Failure	DURATION
Due to	Hypertension	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE W. B. Ford M.D.
M. D. or other
Address Suburban Hospital Date signed Aug. 18, 47

PLAINLY, WITH UNFADING INK. Supply every item ... The correct age ... is especially important. Physicians: please write the cause ... clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93a

07158

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Gaithersburg Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George Washington Darby

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Evelyn W, Darby
6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Aug 11 1891

8. AGE: Years	Months	Days	If less than one day
1891 55	11	22	hrs. min.

9. Birthplace: Washington. D C,
(Town, county, and state)
10. Usual occupation: Stock Forman, (Clerk)
11. Industry or business

FATHER
12. Name: George W, Darby
13. Birthplace: Md,

MOTHER
14. Maiden name: Ester P Gaskin
15. Birthplace: Md,

16. Informant: Evelyn W, Darby
Address: Gaithersburg Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)
Cemetery or crematory: Forest Oak Cemetery
Location: Gaithersburg Md,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg Md,

19. Aug 4 1947 (Date rec'd by registrar) Rhoda L Soule Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3rd 1947, at 11.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1947 to Aug 3 1947 and that I last saw him alive on Aug 3 1947

Immediate cause of death	DURATION
Acute Myocarditis	1/2 hr
Due to	
Due to	
Other conditions Arteriosclerosis	2 yrs
Cerebral Hemorrhage	3/1/47

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. J. Brochart M.D.
M. D. or other
Address: Gaithersburg Md Date signed 8-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

07159

CERTIFICATE OF DEATH

Reg. Diat. No. 217

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville Co. Gen. Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Good Hope Rd Colesville md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Silver Spring R-7 Box
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Maggie Davenport

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 9, 1883

8. AGE:

Years	Months	Days	If less than one day
54			hrs. min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: Home Keeper
11. Industry or business:
FATHER 12. Name: Jeffery Mims
13. Birthplace: Va.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Minnie Rumble
Address: Good Hope Rd. Colesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1947 (month) (day) (year)
Cemetery or crematory: Round Oak
Location: Spencerville, Md
18. Funeral director: Robert L. Snowden
Address: Rockville, Md.
19. 8-23-1947 (Date rec'd by registrar) Gertrude K. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1947, at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1947, to 1947, and that I last saw h alive on 1947

Immediate cause of death	DURATION
Hemorrhage	15 min.
Due to Rupture of Femoral artery and Vein (rt.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 8-23-47
Where did injury occur? Colesville (City or town) Montg (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: gun shot Injured at work? no

23. SIGNATURE: Frank J Broschart M.D. M. D. or other
Address: Gaithersburg Md Date signed: 8-23-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07160

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1600

CERTIFICATE OF DEATH

Reg. Diat. No. 716

M

1. PLACE OF DEATH:

County MONTGOMERY

City or town BETHESDA
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 HOURS

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 13 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County MONTGOMERY

City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9305 GLENNVILLE RD
(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME BABY BOY DAVIS

3. (b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 13 HOURS AUG. 14, 1947

8. AGE:

Years	Months	Days	If less than one day
			13 hrs. 3 min.

9. Birthplace BETHESDA MONT. MD
(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business —

FATHER
12. Name LESTER T DAVIS
13. Birthplace Unknown

MOTHER
14. Maiden name ISABEL B BREY
15. Birthplace BROMEL W. VA

16. Informant MOTHER
Address 9305 GLENNVILLE Rd SILVER SPRING MD

17. Cremation Date thereof Aug. 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D. C.

18. Funeral director Wm Reuben Pumphrey

Address Bethesda, Maryland

19. 8/16 1947 Wm E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 15 1947, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from AUG 14 1947 to AUG 15 1947 and that I last saw h/M alive on AUG 15 1947

Immediate cause of death	DURATION
ASPHYXIA NEONATORUM	
Due to PREMATURE SEPARATION PLACENTA	
Due to	
Other conditions PREMATURITY	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE George B. Spence M.D. M. D., or other

Address 908 Bonifant St. Silver Spring Md Date signed 8-15-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

07161

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Takoma Park.

City or town: Montgomery

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mons.

Hospital, Institution, or street address where death occurred: Spring Villa Convalescent Home

How long in hospital or institution? 3 mon.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Pr. Geo.

City or town: Hyattsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4303 Farragut.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME HARRY E. DAVIS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Eliza Ryman Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9, 1858

8. AGE: Years	Months	Days	If less than one day
89			..... hrs. ..... min.

9. Birthplace: Friendship New York

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Eli Davis

FATHER 13. Birthplace: Mass.

MOTHER 14. Maiden name: Betsy Read

MOTHER 15. Birthplace: Vermont.

16. Informant: Miss Flora E. Davis

Address: 4303 Farragut st. Hyattsville Md.

17. Removal Date thereof Aug 4 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Gasch Funeral Home

Location: Hyattsville, Md.

18. Funeral director: H Gasch Sons

Address: Hyattsville Md.

19. 8/4 1947 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1947, at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1947, to Aug. 4 1947

and that I last saw [illegible] alive on Aug. 4 1947.

Immediate cause of death: Cardiac dilatation — DURATION: 12 hr.

Due to:

Due to:

Other conditions: Arterio sclerosis, infirmities of age. (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. A. Shannon M.D.

M. D. or other

Address: 112 Carroll st. N.W. Date signed: 8-4-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07162

48k

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase (15) Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Montgomery
City or town Chevy Chase (15).
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4700 Hunt ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ZULA GUINN DAVIS.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	WIDOW

6.(b) Name of husband or wife FRANKLIN HILL DAVIS

7. Birth date of deceased (mo., day, yr.) JUNE 28 1893 6.(c) If alive, give age years

8. AGE: Years 54 Months Days If less than one day hrs. min.

9. Birthplace HUNTSVILLE ARK. (Town, county, and state)

10. Usual occupation AT HOME

11. Industry or business

FATHER 12. Name JAME H GUINN
13. Birthplace ARK.

MOTHER 14. Maiden name NANCY STOTTS
15. Birthplace ARK.

16. Informant Mrs Harvey Combs.
Address Little Rock Ark.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-20-47 (month) (day) (year)
Cemetery or crematory —
Location Fayetteville, Ark.,

18. Funeral director Joe Gawler Sons
Address 1756 Penn ave. N.W. wash. D.C.

19. 8/19 (Date rec'd by registrar) 19 47 Mr E Jobe. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19th 1947, at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 12 1947 19 to August 19 1947 and that I last saw h.er alive on August 12 1947

Immediate cause of death	DURATION
Carcinoma of uterus	
Due to ✓	
Due to ✓	
Other conditions De-hydration	

(Include pregnancy within 3 months of death)

Major findings of operations ✓ Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E. A. A. Dr. M. D. or other
Address Bethesda 14, Maryland Date signed Aug 19, 1947

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67163

49a x 8

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg. Co.

City or town: Takoma Park.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days): March 6 1947

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Washington. County: D.C.

City or town: District Of Columbia. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Georgia Ave N.W

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: JENNIE L DAY.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6 (b) Name of husband or wife: Ira C. Day.

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov 9 18 1862

8. AGE: Years	Months	Days	If less than one day
84			____ hrs. ____ min.

9. Birthplace: Mass. (Town, county, and state)

10. Usual occupation: House Wife.

11. Industry or business: Home

FATHER 12. Name: Amos Crane.

FATHER 13. Birthplace: Mass.

MOTHER 14. Maiden name: Unknown.

MOTHER 15. Birthplace: Mass.

18. Informant: Joseph Cavanaugh.

Address

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 8/29/47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery.

Location: FT Myer Va Arl Co.

18. Funeral director: Wilson K. Huntemann

Address: 5732 Georgia Ave N.W.

19. 8/27 19 47 (Date rec'd by registrar) J. Hilton Dodd Registrar

MEDICAL CERTIFICATION

A.M.

20. DATE OF DEATH: August 27th 19 47, at 2:40

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31st 19 41, to August 27th 19 47, and that I last saw her alive on August 23rd 19 47.

Immediate cause of death: Carcinoma of the ovary, metastases — DURATION: Unknown

Due to

Due to

Other conditions: Hypertensive cardiac disease-1941

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Harry G Hadley MD M. D. or other

Address: 1252-6th Street, S.W. Date signed: 8/27/47

07164

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 107 - Park Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 - Park Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Beulah A. Dove
3.(b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: None
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): March ? 1879
8. AGE: Years 68 Months 5 Days ? If less than one day ... hrs. ... min.
9. Birthplace: Rockville - Montg. Co. Md.
(Town, county, and state)
10. Usual occupation: Retired - Teacher
11. Industry or business:

FATHER
12. Name: Thomas R. Dove
13. Birthplace: Rockville - Maryland

MOTHER
14. Maiden name: Lucy Dorsey
15. Birthplace: Flint Hill - Virginia

16. Informant: Mrs. Emmett Dove - Sister in law
Address: 107 - Park St - Rockville - Md -
17. Burial. Date thereof: Aug 16 - 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Rockville Union Cem.
Location: Nr. Rockville - Maryland
18. Funeral director: Wm. Reuben Pumphrey
Address: Rockville - Maryland
19. 8/15 1947 E P Thompson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1947, at 8-45 P.M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Second - 1940, 19..., to August 1947
and that I last saw her alive on August 1947.

	DURATION
Immediate cause of death: Carcinoma of Lung	6 M
Due to: Carcinoma of Breast	5 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)
Major findings of operations: Carcinoma of breast
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Wm A. Tenther By Wellesley, 20
Address: Rockville, Md Date signed 8/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67165

Reg. Dist. No. 723

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: MONTGOMERY

City or town: 805 MAPLE AVE TAKOMA PK. MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? July 31 47 to Aug 26 47

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? July 31, 47 to Aug 26 47

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: 4433 MASS NW County: D.C

City or town: WASHINGTON D.C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4433 YUMA ST. N.W

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY ELLEN EASTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, (widowed) or divorced
F	W	WIDOWED

6.(b) Name of husband or wife: CHARLES EASTON DECEASED

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 8/1/1861

8. AGE:

Years	Months	Days	If less than one day
86		25	..... hrs. ..... min.

9. Birthplace: West VA.

(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER 12. Name: RICHARD O'LEARY

FATHER 13. Birthplace: IRELAND

MOTHER 14. Maiden name: MARGARET JUHN

MOTHER 15. Birthplace: IRELAND

16. Informant: MRS SNYDER

Address: 4433 YUMA ST N.W

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/26/47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: The L.H. Hines Co

Address: 2501 - 4th St N.W.

19. Aug 26 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 19 47, at 11:15 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 16 19 47 to Aug 26 19 47

and that I last saw her alive on Aug 22 19 47

Immediate cause of death	DURATION
Cardiorespiratory failure	acute
Due to: Senility	
Due to:	
Other conditions: Unexplained Diarrhea	three weeks months

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Peter P. Brue M.D. M. D. or other

Address: 4343 Davenport St. N.W. Date signed: Aug 26, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67166

472

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital 8600 Georgetown Rd.

How long in hospital or institution? 39 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State D.C. County

City or town Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 5709 33rd St N.W. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Hermina Edelschein

3. (b) Social Security Number

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Theodore Edelschein

6. (c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) April 4 1902

8. AGE: Years 45 Months 4 Days 10 If less than one day ... hrs. ... min.

9. Birthplace Hungary (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Ecker

13. Birthplace Hungary

MOTHER 14. Maiden name ?

15. Birthplace Hungary

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1947 (month) (day) (year)

Cemetery or crematory Arlington Nat. Cem.

Location Arlington Va.

18. Funeral director The S.H. Hines Co.

Address 2901 14th. st. N.W

19. 8/14 1947 Mrs E. Jobes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947, at 5-05 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 August 1947, to 14 Aug 1947

and that I last saw her alive on 13 Aug 1947

Immediate cause of death: Carcinoma Lt. lung with metastasis to lymph nodes and right lung. | DURATION: unknown

Due to

Due to

Other conditions (Include pregnancy within 3 months of death): Pulmonary edema, Bronchopneumonia right and left lung. (less than 1 day)

Major findings of operations

Date of op.

Autopsy results see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address 5522 Western Ave Date signed 14 Aug 47


RECEIVED
AUG 21 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67167

526 K S

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 56 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Victory Hotel

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME: ELLINGTON, Richmond "C"

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowered

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 2 November 1887

8. AGE: Years: 59 Months: 9 Days: 28 If less than one day: hrs. min.

9. Birthplace: Alabama (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: laborer

FATHER 12. Name: M. L. Ellington

FATHER 13. Birthplace: Alabama, deceased

MOTHER 14. Maiden name: Cordelia Arnett

MOTHER 15. Birthplace: Alabama, deceased

16. Informant: Daughter; Mrs. Mary Presley

Address: Presley La., E. Riverdale, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9-4-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. RWB

Address: 5801 Cleveland Ave., Riverdale, Md.

19. 8-31 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 30 August 19 47 at 2:19 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-5- 19 47, to 8-30- 19 47 and that I last saw him alive on 8-30- 19 47

Immediate cause of death	DURATION
Uremia	1 week
Due to ascending pyoureter and pyonephrosis following a left ureterosigmoidostomy done because of advanced carcinoma of the urinary bladder	? 2 years

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of urinary bladder

Date of op.

Autopsy result: Carcinoma bladder, pyonephrosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. N. Quilter T.N.QUILTER, LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed: 8-30-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(1)

9/5147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

67168

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Kensington, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Kensington, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isabella Stevenson Ellis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	married

6.(b) Name of husband ~~or wife~~ Charles Ellis

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) July 6, 1900

8. AGE: Years 47 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Mt Zion, Maryland (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Charles Magruder

13. Birthplace Md.

MOTHER 14. Maiden name Carrie Hawkins

15. Birthplace Maryland.

16. Informant Charles Ellis

Address Kensington, Md R

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4 1947 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Mt Zion, Md.

18. Funeral director Robert R. Snowden

Address 246 N. Wood St. Rockville Md

19. Aug 4 1947 (Date rec'd by registrar) Josephine C. Schaffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1947, to Aug 1 1947

and that I last saw h.e.r. alive on July 31 1947

Immediate cause of death Coronary Thrombosis — DURATION

Due to Myocardial Infarctions — 1941

Due to Hypertension — ?

Due to Arteriosclerosis — ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Webster Sewell M.D.

M. D. or other

Address Norbeck Md Date signed Aug 3 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161a

CERTIFICATE OF DEATH

67169

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hours; 16 minutes

Hospital, institution, or street address where death occurred: Washington Sanitarium + Hospital

How long in hospital or institution? 6 hours; 16 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: County:

City or town: Takoma Pk.

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy FLOEGEL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1947

8. AGE:

Years	Months	Days	If less than one day
			6 hrs. 16 min.

9. Birthplace: Montgomery (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: MERLE ERNEST FLOEGEL

13. Birthplace: DENVER, COLORADO

MOTHER

14. Maiden name: MARGARET LUCILLE KOHLER

15. Birthplace: Boulder, Colorado

16. Informant: Washington Sanitarium + Hospital

Address: TAKOMA PARK 12, MARYLAND

17. (Burial, cremation, or removal. Which?) Burial Date thereof: (month) Aug (day) 10 (year) 1947

Cemetery or crematory: George Washington Mem.

Location: Hyattsville, Maryland

18. Funeral director: J. Arthur Walters

Address: 254 Carroll St. Takoma Park, Md

19. (Date rec'd by registrar) 8/50 1947 Registrar: William Dodd

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1947, at 7:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-9-47 (1:14 pm) 19.. to 7:30 pm (8-9-47) and that I last saw him alive on 8-9-47 19..

Immediate cause of death	DURATION
Respiratory Failure	
Due to: Congenital Atelectasis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dean W. Harding M.D. M. D. or other

Address: 113 Carroll St NW Wash DC Date signed: 8-9-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67170

Reg. Dist. No. 212

1. PLACE OF DEATH:

County: Montgomery

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 yrs mos

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Monty.

City or town: Poolesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Isaac Fyffe

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Bettie D Fyffe

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): May 27 1884

8. AGE:

Years	Months	Days	If less than one day
73	2	9	hrs. min.

9. Birthplace: Poolesville, Monty Co Md.

(Town, county, and state)

10. Usual occupation: Retired farmer

11. Industry or business

FATHER

12. Name: Thomas Fyffe

13. Birthplace: Md.

MOTHER

14. Maiden name: Mary A Hult

15. Birthplace: Maryland

16. Informant: Miss Virginia Fyffe

Address: Poolesville, Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 8 1947 (month) (day) (year)

Cemetery or crematory: Monocacy

Location: Beallsville, Md

18. Funeral director: William B. Hilton

Address: Poolesville.

19. Aug. 19 47 (Date rec'd by registrar) Barnesville Md [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6- 1947, at 6.20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1- 1947, to Aug. 6- 1947

and that I last saw him alive on Aug. 5- 1947

Immediate cause of death: Carcinoma of liver — DURATION: 2 yrs-

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Byron D. White, Md. M. D. or other

Address: Poolesville, Md. Date signed: 8/7/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
AUG 9
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Item #15 Film #-423 4/7/48 462 2

07171

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery Co.

City or town Chevy Chase Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 215 East Underwood St

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME Leonice T. Garfield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Leonard D. Garfield

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1858

8. AGE:

Years	Months	Days	If less than one day
88			..... hrs. ..... min.

9. Birthplace Mass. (Abington)

(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Simeon Thompson

13. Birthplace Mass.

MOTHER 14. Maiden name Sarah Faulkner

15. Birthplace Mass Nova Scotia

16. Informant Mrs. George H. Priest Jr.

Address 215 East Underwood St

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 27/47 (month) (day) (year)

Cemetery or crematory Milbury Mass Cemetery

Location Milbury Mass

18. Funeral director Chevy Chase Funeral Home

Address 5103 Wis ave N W

19. Aug 26 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 August 1947 at 9:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 August 1947 to 24 Aug. 1947 and that I last saw her alive on 24 August 1947

Immediate cause of death	DURATION
Pulmonary Embolism, left.	One hour
Due to Bilateral deep Femoral vein thrombosis	20 hours
Due to	
Other conditions Carcinoma of cecum with carcinomatosis of abdomen (Include pregnancy within 3 months of death)	8 years

Major findings of operations —

Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of .....

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE Stewart Clapp M.D. (M. D. or other)

Address 3921 Ingoman St. N.W. Wash D.C. Date signed 8-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

8-25-47

67173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#2 - Emory Grove.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Holland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 30, 1947

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 40 min.

9. Birthplace Olney, Montgomery Co. Maryland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Sterling Howard Duvall

13. Birthplace Emory Grove, Maryland

MOTHER 14. Maiden name Pauline Holland

15. Birthplace Emory Grove, Maryland

16. Informant Hospital records.

Address

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8-30-47 (month) (day) (year)

Cemetery or crematory Monty Co. Gen. Hosp.

Location Olney, Md.

18. Funeral director J. M. Leishear Supt.

Address Olney, Md.

19. Aug 30 1947 Gertrude B. Lawson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1947, to August 30 1947 and that I last saw him alive on August 30 1947

Immediate cause of death	DURATION
Prematurity	4 mts.
Due to Unknown.	
Due to (Weight 12½ oz.)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md. Date signed 8/30/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

67174

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Comus

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montg.

City or town Comus.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Annie Mary Holland

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Geo. Otis Holland

6.(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Oct. 27-1875

8. AGE:

Years	Months	Days	If less than one day
71	10	5	hrs. min.

9. Birthplace Buck Lodge. Montg Co Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER

12. Name John Nicholson

13. Birthplace Md

FATHER

14. Maiden name Martha Johnsond

15. Birthplace Md.

16. Informant G. Otis Holland

Address Comus, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/26/47 (month) (day) (year)

Cemetery or crematory Monocacy

Location Beallsville, Md

18. Funeral director William B. Hilton

Address Barnesville, Md

19. Aug. 25 1947 (Date rec'd by registrar) Mrs. C. C. Hilton By M. C. B. H. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 23 1947, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July - 31 - 1947 to Aug-23- 1947

and that I last saw h.. alive on Aug - 22 - 1947

Immediate cause of death	DURATION
Cerebral Hemmhage	4 days
Due to Arteriosclerosis -	1 yr
Due to	
Other conditions Leukocytosis negligible and Glycosuria	1 month

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William E. Miller, M.D. M. D. or other

Address Gaithersburg, Md. Date signed 8/24/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

67172

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: Montgomery

County 405 Highland Dr.

City or town Kenwood, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Kenwood, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 405- Highland Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Ethlyn Houghton H. Gunnell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: John H. Gunnell

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): May 11, 1883

8. AGE: Years	Months	Days	If less than one day
64			...hrs. ...min.

9. Birthplace: Milwaukee, Wisconsin (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles B. Houghton

13. Birthplace: Milwaukee, Wisconsin

MOTHER — 14. Maiden name: Emma A. Sweet

15. Birthplace: Michigan

16. Informant: John H. Gunnell

Address 405 Highland Drive, Kenwood, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8/25/47 (month) (day) (year)

Cemetery or crematory Arlington National

Location

18. Funeral director The D. H. Nuss Co

Address 2901- 14th St. N.W.

19. 8/23/1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23- 1947 at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1945 to aug 23 1947 and that I last saw h... alive on 21 aug 1947

Immediate cause of death	DURATION
Debilitation	
Due to carcinomatosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of the ovary. Date of op. aug 10, 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury Injured at work?

23. SIGNATURE Edward L. Wilson M.D. M. D. or other

Address 1801- Eye St. N.W. Date signed 23 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67175

39C

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....
(If rural, give LOCATION)

2.(a) If veteran, name war: WW2

3.(a) FULL NAME: HUNGERFORD, William Roger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife: ....

6.(c) If alive, give age ....years

7. Birth date of deceased (mo., day, yr.): December 16, 1917

8. AGE:

Years	Months	Days	If less than one day
29	8	12	....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Clerk in Restaurant

11. Industry or business: ....

FATHER
12. Name: HUNGERFORD, William C.
13. Birthplace: Md.

MOTHER
14. Maiden name: PEDDICORD, Lillian
15. Birthplace: Md.

16. Informant: FATHER: Mr. William C. Hungerford
Address: Germantown, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-31-47 (month) (day) (year)

Cemetery or crematory: Cedar Grove Cemetery
Location: Cedar Grove, Md.

18. Funeral director: Roy Barber R. B.
Address: Laytonsville, Md.

19. 8- 28 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 28 1947, at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 August 1947, to 28 Aug. 1947 and that I last saw him alive on 28 August 1947

Immediate cause of death	DURATION
Perforated gastric ulcer	Undet.
Due to acute septicemia	Undet.
Due to Rocky Mt. Spotted fever	Undet.
Other conditions R.U.L. pneumonia	24 hrs

(Include pregnancy within 3 months of death)

Major findings of operations: ....

Autopsy results: Hemorrhagic diathesis, splenic tumour, perforated gastric ulcer, R.U.L. pneumonia. Date of op. ....

PHYSICIAN: Please underline the cause(s) which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: H. F. Singleton H. F. SINGLETON, Lt.(jg) MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed 8-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 8-45-15M

9/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. [illegible]

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County MONTGOMARY
City or town SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
8005 - EASTERN AVE.
How long in hospital or institution? 10 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County MONTGOMARY
City or town SILVER SPRINGS
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8005 - EASTERN AVE
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME REBECCA IMBER

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	MARRIED

8.(b) Name of husband or wife JOSEPH IMBER
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1886

8. AGE: Years	Months	Days	If less than one day
64			....hrs. ....min.

9. Birthplace Russia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name ISAAC PODOLSKY
13. Birthplace RUSSIA

MOTHER
14. Maiden name EVA GOLDSTEIN
15. Birthplace RUSSIA

16. Informant JOSEPH IMBER
Address 8005 EASTERN AVE. SILVER SPRING MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof AUGUST 31 1947 (month) (day) (year)
Cemetery or crematory National Capital Memorial Cemetery
Location Washington, D.C.

18. Funeral director B. Danzansky & Son
Address 3501-14th St N.W.

19. Aug 27 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 AUGUST 1947, at 10:29 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 MARCH 1947, to 28 AUGUST 1947 and that I last saw Mr. alive on 26 AUGUST 1947

Immediate cause of death	DURATION
General Visceral failure	
Due to Adenocarcinoma of rectum	10 mo.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Leo H. Mengmore M. D. or other
Address 1243 Good Hope Rd S.E. Date signed 28 Aug 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

67177

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital Inc.

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Laytonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr. Robert Inches

3.(b) Social Security Number 577-24-1200

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Elizabeth Inches

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1887

8. AGE: Years 60 | Months 2 | Days 28 | If less than one day ... hrs. ... min.

9. Birthplace Scotland
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Robert Inches

13. Birthplace Scotland

MOTHER 14. Maiden name Ann

15. Birthplace Scotland

18. Informant Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6, 1947 (month) (day) (year)

Cemetery or ~~crematory~~ ~~St. John's~~ Laytonsville Cem.

Location ~~Olney Md~~ Laytonsville Md

18. Funeral director Roger Brady

Address Laytonsville md.

19. Aug 4 1947 (Date rec'd by registrar) Gertrude R. Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1947, at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1947, to Aug. 4 1947

and that I last saw him alive on August 4 1947

Immediate cause of death Uremia — DURATION 10 days

Due to Arteriolar Nephrosclerosis — 7 yrs

Due to

Other conditions Hypertensive Cardio-vascular disease 7 yrs
Pulmonary emphysema & fibrosis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Sandy Spring, Md Date signed 8/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67178

159

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Seneca, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Rural
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Seneca
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Upton H. Jackson, Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	sing

6.(b) Name of husband or wife: ✓

7. Birth date of deceased (mo., day, yr.): August 8th - 10 - 47

6.(c) If alive, give age: years

8. AGE:

Years	Months	Days	If less than one day
0	0	0	7 hrs. 15 min.

9. Birthplace: Seneca, Md.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business: ✓

FATHER
12. Name: Upton H. Jackson
13. Birthplace: Seneca, Md.

MOTHER
14. Maiden name: Elizabeth I. McDonald
15. Birthplace: Damascus, Md.

16. Informant: Elizabeth L. Jackson
Address: Germantown, Md. - Route 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 10 1947 (month) (day) (year)

Cemetery or crematory: Seneca

Location: Seneca, Md.

18. Funeral director: Upton H. Jackson Sr.
Address: Seneca, Md.

19. Aug. 10 1947 (Date rec'd by registrar) Mrs E. P. Thompson Asst. S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug - 10 - 1947 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 1947, to Aug - 10 - 1947 and that I last saw h[illegible] alive - Aug - 10 - 1947

Immediate cause of death	DURATION
premature Birth - 6-7 mo - conception	
Due to Birth weight - 3 lbs - 12 oz.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William B. Miller M.D.
M. D. or other
Address: Gaithersburg, Md. Date signed: 8-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

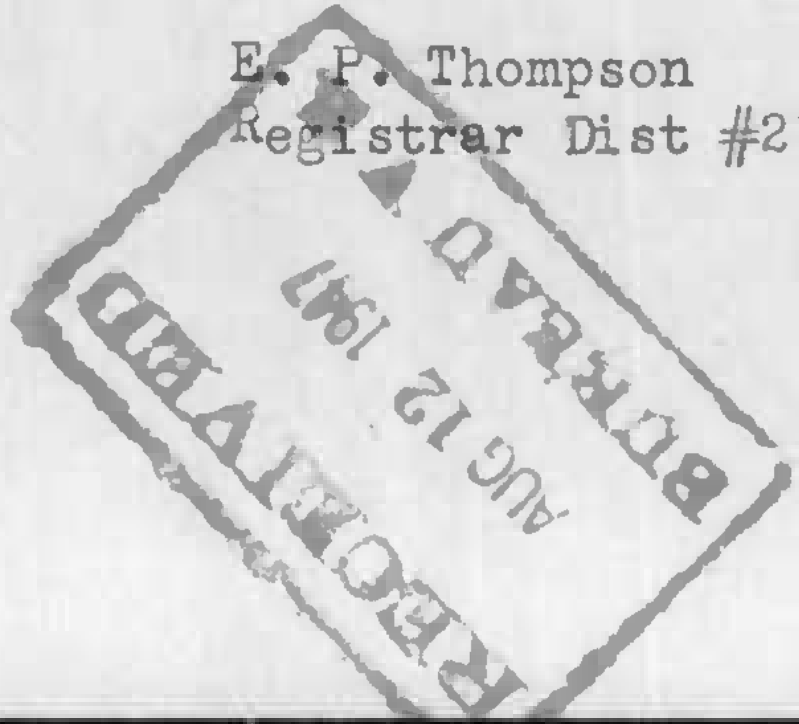
C. V. Hartnell

9.30
2.15
7.13

Upton H. Jackson Jr. 8/11/47

You will note that the date of birth is given as October 10 instead of August 10.

E. P. Thompson
Registrar Dist #213



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07179

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Ashton Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 90 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Ashton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Isabella Johnson

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Thomas R Johnson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Nov 22 - 1856

8. AGE: Years 90 | Months 7 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Montgomery Co Md
(Town, County, and state)
10. Usual occupation None
11. Industry or business None
FATHER 12. Name Richard Tucker
13. Birthplace Montgomery Co Md
MOTHER 14. Maiden name Mary A Murphy
15. Birthplace Montgomery Co Md
16. Informant Mrs Hurbert Cuff
Address Ashton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17 1947 (month) (day) (year)
Cemetery or crematory Union Burtonsville
Location Montgomery Co Md
18. Funeral director Roy W Barber
Address Burtonsville Md
19. 8-16-1947 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947 at 11:20 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 1 - 1947 to aug 15 - 1947 and that I last saw her alive on aug 13 - 1947

Immediate cause of death	DURATION
Hypertension	
Heart disease	5 years
Due to Arteriosclerosis	unknown
Due to	
Other conditions Extreme age	

(Include pregnancy within 3 months of death)
Major findings of operations no Date of op.
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Chas E Tumbleson M. D. or other
Address Sandy Spring Md Date signed 8/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

V8 A15 9-45-15M

Johnson, Ollie

67180

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Glen (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen (If outside city or town limits, write RURAL and give nearest town)
Street No.: None (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Ollie Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John T. Johnson
6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): June 24, 1872

8. AGE: Years	Months	Days	If less than one day
75	1	20	hrs. min.

9. Birthplace: Oaklon, Virginia (Town, county, and state)
10. Usual occupation: None
11. Industry or business: None

FATHER
12. Name: George T. Cook
13. Birthplace: Virginia

MOTHER
14. Maiden name: Sarah Williams
15. Birthplace: Virginia

16. Informant: Mrs. Ruth Pettitt
Address: RFD # 1 Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 16, 1947 (month) (day) (year)
Cemetery or crematory: Flint Hill
Location: Fairfax County, Virginia

18. Funeral director: W. Reuben Thompkins
Address: Rockville, Md.

19. 8/14 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 13 1947, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1947, to Aug 13 1947
and that I last saw h[illegible] alive on August 9 1947

Immediate cause of death	DURATION
Congestive heart Failure	6 Months
Due to: Myocardial degeneration	5 Years
Due to:	
Other conditions: Severe Osteo-arthritis	-

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Willie Webb M. D. or other
Address: Rockville, Md Date signed: 8/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67181

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318

CERTIFICATE OF DEATH

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Lincoln Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Lincoln Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Elisabeth Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife John E. Jones 6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) April 4, 1890

8. AGE: Years	Months	Days	If less than one day
57			hrs. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual occupation House keeper
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace

MOTHER
14. Maiden name Peters Hatcher
15. Birthplace Virginia

16. Informant John E. Jones
Address Lincoln Park. Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof August 17 1947 (month) (day) (year)
Cemetery or crematory Lincoln Park,
Location Rock Hall, Md.

18. Funeral director Robert L. Snowden
Address 246 N. Washington St.

19. Aug. 17 1947 (Date rec'd by registrar) Mrs E.P. Thompson Md.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1947 at 6:8 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1947 to Aug 14 1947 and that I last saw h.. alive on 8-13 1947

Immediate cause of death	DURATION
Chronic Nephritis	9 months
Due to Chronic Myocarditis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Calvin B. LeCompte M. D. or other
Address Wheaton Md Date signed 8/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67182

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 mos., 8 days

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 9 mos., 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Army and Navy Club

(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American & WW I

3.(a) FULL NAME: JONES, Needham Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowered

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7 December 1875

8. AGE: Years: 71 | Months: 8 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Missippi (Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business: Retired Inactive

FATHER

12. Name: Stephen Jones

13. Birthplace: Georgia, deceased

MOTHER

14. Maiden name: Maria Sarah Hatch

15. Birthplace: Missippi, deceased

16. Informant: Daughter: Mrs. William R. Clark

Address: Star Route, Willimantie, Connecticut

17. burial (Burial, cremation, or removal. Which?) Date thereof: 9- 3- 47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Joseph Gawler Co.

Address: 1756 Pennsylvania Ave., NW, Wash., D.C.

19. 8-31 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 August 1947 at 12:12 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-22- 1946 to 8-31- 1947 and that I last saw him alive on 8-31- 1947

Immediate cause of death: Bronchopneumonia DURATION 1 wk.

Due to: Terminal state

Due to: Cerebral thrombosis

Other conditions: Tabes Dorsalis

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: F. P. KREUZ, CAPT MC USN M. D. or other

Address: USNH, Bethesda, Md. Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07183

83a

216

Reg. Dist. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2808 S Joyce Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: KEARNEY, Clarence Michael, CQM USN Ret.Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mary Kearney

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 12, 1896

8. AGE: Years	Months	Days	If less than one day
51	2	7	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Chief Deputy Marshal

11. Industry or business: Department of Justice

FATHER
12. Name: Kearney, Patrick dec.
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: WALKER, Ida dec.
15. Birthplace: Scotland

16. Informant: Wife: Mrs. Mary Kearney

Address: 2808 S Joyce St., Arlington, Va.

17. burial (Date thereof) 8-22-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: S. H. HINES S.H.

Address: 2901 14thSt.,N.W.,Wash.,D.C.

19. 8-20- 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 August 1947 at 3:33 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 August 1947 to 19 August 1947 and that I last saw h... 1m alive on 19 August 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE, RIGHT	8 hours
Due to HYPERTENSION, ESSENTIAL	6 YEARS
Due to CEREBRAL ARTERIOSCLEROSIS	
Other conditions GENERALIZED ARTERIOSCLEROSIS, MINIMAL	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: (SAME AS ABOVE)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, Lt.(jg) MC USNR
M. D. or other

Address: USNH Bethesda,Md. Date signed: 8-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67184

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 2-16

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 x yrs

Hospital, institution, or street address where death occurred:

9001 Georgetown Rd

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9001 Georgetown Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Sister Patricia Kearney

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	W	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 13 1874

8. AGE:

Years	Months	Days	If less than one day
73	2	18	____ hrs. ____ min.

9. Birthplace: County Tyrone - Ireland (Town, county, and state)

10. Usual occupation: Sister of Visitation

11. Industry or business: —

FATHER 12. Name: James Kearney

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Jane Corbett

MOTHER 15. Birthplace: Ireland

16. Informant: Mother Superior Visitation

Address: Bethesda Md

17. Burial, cremation, or removal. Which?: Burial — Date thereof: Aug 7 1947 (month) (day) (year)

Cemetery or crematory: Sisters of Visitation Cemetery

Location: Bethesda Maryland

18. Funeral director: W. W. Chambers Co

Address: 3022 M St NW

19. 9-2 1947 (Date rec'd by registrar) W.E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 19 47 at 1 a.m. p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 19 to ____ 19 ____ and that I last saw h alive on ____ 19 ____

Immediate cause of death	DURATION
Coronary occlusion	days
Due to	months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: Frank J. Bouchard M.D. Dep. Med. Exam. M. D. or other

Address: Gaithersburg Md Date signed: 9-2-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50 ∝

07185

CERTIFICATE OF DEATH

Reg. Dist. No. 7-16

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda / Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Seven or Eight years
Hospital, institution, or street address where death occurred:
Suburban
How long in hospital or institution? 2 days 13½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 448 Grosvenor Lane Bethesda
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Ida May Keiser

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife John Keiser
Divorced 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) September 1, 1870

8. AGE: Years	Months	Days	If less than one day
76	11	23	..... hrs. ..... min.

9. Birthplace Montgomery Co Md.
(Town, county, and state)
10. Usual occupation Retired Seamstress
11. Industry or business None

FATHER
12. Name Amos
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden name Mary Cole
15. Birthplace Montgomery Co Md.

16. Informant Mrs Nellie F. Pore (friend)
Address 4011 Chesapeake St. N.W. Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1947 (month) (day) (year)
Cemetery or crematory Mt. Zion Cemetery
Location Bethesda, Maryland
18. Funeral director W. Reuben Turnbaugh
Address Bethesda, Maryland

19. 8/23 1947 Wm E Jobes
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1947 at 1 36 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 Med. Exam 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Carcinoma of breast (left)	1½ yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank J. Brockett M.D. Asst Med Exam M. D. or other
Address Gaithersburg Md Date signed 8-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67186

Reg. Dist. No. 5-14

1. PLACE OF DEATH:

County: Mont

City or town: Spencerville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Mont

City or town: Spencerville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Mrs Sarah Emma Kelley

3. (b) Social Security Number: no

4. Sex: fem

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: John W. Kelley

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 2nd 1856

8. AGE: Years: 90 Months: 11 Days: 10 If less than one day: hrs. min.

9. Birthplace: Spencerville - Mont Co (Town, county, and state)

10. Usual occupation: Retired minister

11. Industry or business: Methodist Church

FATHER 12. Name: Louis Duvall

FATHER 13. Birthplace: Md

MOTHER 14. Maiden name: Mary A Spencer

MOTHER 15. Birthplace: Mont Co Md -

18. Informant: Mrs Edna Stackhouse

Address: Spencerville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-22-47 (month) (day) (year)

Cemetery or crematory: Burtonsville Union Cem.

Location: Burtonsville, Md

19. Funeral director: Wm R. Humphrey

Address: Bethesda, Md

19. Aug 21 1947 (Date rec'd by registrar) Josephine A Shaffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-20- 1947, at 9:50 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15- 1947, to Aug 20- 1947

and that I last saw h-- alive on Aug 19- 1947

Immediate cause of death: Chronic Myocarditis with nephritis — DURATION: 20 Mo

Due to: —

Due to: —

Other conditions: Extreme age

(Include pregnancy within 3 months of death)

Major findings of operation: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas E Trumbleson M. D. or other

Address: Sandy Spring Date signed 8/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of mother's propername is shown on G 112 9/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a S

07187

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 308 E. Capitol St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW1

3.(a) FULL NAME: LANE, William Lawrence

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 23 June 1891

8. AGE: Years	Months	Days	If less than one day
56	1	16	hrs. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Automobile Mech.
11. Industry or business

FATHER
12. Name: LANE, Timothy
13. Birthplace: Ireland

MOTHER
14. Maiden name: SULLIVAN, Anna Hannah
15. Birthplace: Ireland

16. Informant: sister: Miss Ella Mae Lane
Address: 308 E. Capitol St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-14-47 (month) (day) (year)
Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS F. & K.
Address: 517 11th St., S.E., Wash., D.C.

19. 8-11 (Date rec'd by registrar) 1947 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 August 1947 at 4:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 August 1947 to 9 August 1947 and that I last saw him alive on 9 August 1947

Immediate cause of death	DURATION
Brain abscess	3 Days
Subarachnoid hemorrhage	3 Days
Due to: Mastoiditis	12 Days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. C. Messerschmidt
H. C. MESSERSCHMIDT, Lt. (jg) MC) USNR
Address: USNH Bethesda, Md. M. D. or other
Date signed: 8-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/14/47

BIRTH AND DEATH 67188

MARYLAND STATE DEPARTMENT OF HEALTH 161c B 216

CERTIFICATE OF ~~STILLBIRTH~~ Reg. Dist. No.

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Montgomery
   City or town: Bethesda (rural)
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: US Naval Hospital, Bethesda, Md.
   Length of mother's stay in County: 1 day
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: Washington, D. C.
   County:
   City or town:
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: 3910 Tunlaw Terrace, N.W. ✓
   (If RURAL give LOCATION)

3. Name of child: LEONARD, Carolyn Ruth
4. Date of birth: 8-2-47 Hour: 8:22 P M.
5. Sex: female
6. Twin or triplet: -
7. No. of weeks pregnancy: 9 months

FATHER OF CHILD

8. Full name: LEONARD, Roy Harris
9. Color: W-US
10. Age at time of this birth: 26 yrs.
11. Usual occupation: Navy

MOTHER OF CHILD

12. Full maiden name: HUDSON, Mary Lois
13. Color: W-US
14. Age at time of this birth: 23 yrs.
15. Usual occupation: housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living?
    (b) How many other children were born alive but are now dead? (c) How many other children were *born* dead?

17. Did child die before labor? NO During labor? NO
18. Pregnancy, complications of: Rh antibodies
19. Labor: (a) Complications of: -NO-
    (b) Induced? NO
20. (a) Was there an operation for delivery? NO (Yes or No)
    (b) State all operations, if any: None
    (c) Did child die before operation? -
    During operation? -

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Erythroblastosis, marked-
    (b) Maternal causes: Rh negative with Rh positive antibodies

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
    Signature: Paul Peterson PAUL PETERSON, Capt. (MC) USN
    (Specify if M. D., midwife, or other)
    Address: USNH Bethesda, Md.

23. (a) burial (Burial, cremation or removal) (b) Date thereof 8-7-47 (month) (day) (year)
    (c) Cemetery or crematory: Arl. Nat'l. Cem., Arl., Va.
24. (a) Funeral director: W. W. CHAMBERS
    (b) Address: 1400 Chapin St., N.W., Wash., D.C.

25. (a) 8-6-47 (Date rec'd by registrar) (b) Mary Charlotte Smith (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

* See Instruction C on stub.

Baby Lived 8 hours, 13 minutes

V. S. A10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67189

Reg. Dist. No. 216

record 4th 462

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos 16 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 758 6th Street, Southeast
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I ✓

3.(a) FULL NAME: Charles Solomon LEWIS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mrs. Celia Lewis

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 1 April 1890

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
57	4	1		

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Accountant

11. Industry or business: General Accounting Office

FATHER
12. Name: Z. Lewis
13. Birthplace: Russia, dec.

MOTHER
14. Maiden name: Dorothy Davis
15. Birthplace: Russia, dec.

16. Informant: Wife: Mrs. Celia Lewis
Address: 758 6th St., SE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers
Address: 517 11th St., SE, Washington, D. C.

19. 8-4- 1947 (Date rec'd by registrar) mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 August 1947, at 7:18 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-17 1947, to 8-2 1947 and that I last saw h... im alive on 8-2- 1947

	DURATION
Immediate cause of death: Terminal, Bronchopneumonia	3 days
Due to: Adenocarcinoma of rectum with multiple metastases.	? months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Cf. above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Halim H. Halik M. D.
M. D. or other

Address: National Naval Medical Center Date signed: 4 Aug '47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

8/8/47

67190

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131a

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Cedar Grove RFD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: None
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Cedar Grove RFD
(If outside city or town limits, write RURAL and give nearest town)
Street No. Germantown RFD
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME MARY VIRGINIA LINTHICUM

3.(b) Social Security Number No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Grover D. Linthicum
6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) August 29, 1894

8. AGE: Years	Months	Days	If less than one day
52	11	21	hrs. min.

9. Birthplace Leesburg, Virginia (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None

FATHER
12. Name Thomas Carlisle
13. Birthplace Virginia

MOTHER
14. Maiden name Catherine Williams
15. Birthplace Unknown

16. Informant Grover D. Linthicum
Address Germantown RFD, Cedar Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Grover Date thereof August 22, 1947 (month) (day) (year)
Cemetery or crematory Cedar ~~Hill~~ Grove Bapt. Ch. Cem.
Location Cedar ~~Hill~~ Grove, Maryland

18. Funeral director Wm. Reuben Humphrey
Address Rockville, Maryland

19. Aug 21 1947 (Date rec'd by registrar) Alsuda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947 at 12 36 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 1 1947 to Aug 20 1947 and that I last saw her alive on Aug 20 1947

Immediate cause of death	DURATION
Acute heart failure	½ hour
Due to Cardio-nephritis	1 year
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causee, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE William C. Miller M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 8/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

67191

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 days
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Helen Amelia Lowe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Arthur b. lowe
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept. 1, 1897

8. AGE: Years	Months	Days	If less than one day
49	11	28	hrs. min.

9. Birthplace: Terre Haute, Indiana (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Ernest Boberg
13. Birthplace: Indiana

MOTHER
14. Maiden name: Elizabeth Barbara Seifort
15. Birthplace: Indiana

16. Informant: Husband, Arthur b. Lowe
Address: R.F.D. #3, Gaithersburg, Md.

17. (Burial, cremation, or removal. Which?) (Burial) Date thereof: Sept. 2, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Md.

18. Funeral director: Geo. W. Kise Co. Inc.
Address: 1900 M. St. N.W. Wash. D.C.

19. 9/29 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 29, 1947 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Aug 47 19 , to 28 Aug 19 47
and that I last saw h alive on 28 Aug 47 - 3PM. 19
Immediate cause of death: CARDIAC EMBOLISM 2 H 25 — DURATION
Due to: HYPOSTATIC PNEUMONIA (L.) — 3 DAYS
Due to: COMPLICATIONS OF CHOLECYSTECTOMY
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: SUB ACUTELY INFLAMED GALL BLADDER, LARGE GALL STONE, ADHESIONS Date of op. 25 Aug 47
Autopsy results: NOT DONE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Marcus M.D. M. D. or other
Address: 9211 Tenafly Ave-Silver Spring Date signed 29 Aug 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67192

CERTIFICATE OF DEATH

Reg. Diat. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

100 Baltimore Avenue

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland — County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 100 Baltimore Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME SUSIE LYTTLE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1878

8. AGE: Years 68 | Months 10 | Days 15 | If less than one day: hrs. min.

9. Birthplace: Indiana (Town, county, and state)

10. Usual occupation: U.S. Government Employee

11. Industry or business: Engrav. & Printing

FATHER — 12. Name: [illegible]

FATHER — 13. Birthplace:

MOTHER — 14. Maiden name: [illegible]

MOTHER — 15. Birthplace:

16. Informant: Mrs E. Longacre

Address: 102 Park Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2, 1947 (month) (day) (year)

Cemetery or crematory: Geo Wash. Mem. Cemetery

Location: Riggs Rd., Hyattsville, Md.

18. Funeral director: J. Arthur Walters

Address: 7th & Kansas St. Tak Pk, D.C.

19. Sept. 2 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1947, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1947 to Aug 31 1947 and that I last saw her alive on Aug 31 1947

Immediate cause of death	(a)	Lobar pneumonia	4 days
Due to	(b)		
Due to	(c)		
Other conditions			

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other

Address: Silver Spring Md Date signed: Aug 31 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1256

67193

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 days

Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6711 Exfair Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: MACIAS, Joseph Shirley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 30 October 1898

8. AGE:	Years	Months	Days	If less than one day
	48	9	14	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Joseph Macias
13. Birthplace: Cuba, dec.

MOTHER
14. Maiden name: Mercedes Yznaga
15. Birthplace: Cuba, dec.

16. Informant: Sister: Mrs. Virginia Humes

Address: 6711 Exfair Rd., Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-15-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia E & B.

18. Funeral director: V. L. Speare Co.

Address: 1009 H St., NW, Washington, D. C.

19. 8-13 1947 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 August 1947 at 5:19 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-18 1947 to 8-13-47 1947 and that I last saw him alive on 8-13-47 1947

Immediate cause of death	DURATION
(a) Acute Septicemia	1 mo.
Due to: Pylephlebitis and multiple liver abscesses	3½ weeks
Due to: Acute diverticulitis (Sigmoid)	4½ weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As reported above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul R. Engle PAUL R. ENGLE, CDR MC USN M. D. or other

Address: USNH, BETHESDA, MD. Date signed: 8-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

8/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

7508

13/a

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Montros
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW1

3.(a) FULL NAME: MIDDLETON, Ramey Kilreen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 15 February 1892

8. AGE: Years	Months	Days	If less than one day
55	5	26	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business

FATHER
12. Name: John MIDDLETON, dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: Julia HARRISON dec.
15. Birthplace: Va.

16. Informant: brother: Mr. Archie Middleton
Address: Montros, Virginia

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-15-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS A.P.
Address: 1400 ChapinSt., N.W., Wash., D.C.

19. 8-12 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11 August 1947 at 8:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 July 1947 to 11 August 1947 and that I last saw h... alive on Aug 11, 1947

Immediate cause of death	DURATION
Uremia	
Due to: Hypertension with hypertensive heart changes.	
Due to: General neural failure - Arteriosclerosis + Nephritis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hugh Stevens Jr. LTJG (MC) USNR
HUGH STEVENS, Jr. Lt. (jg) M.C. USNR
Address: NNMC Bethesda, Md. Date signed: 8-11-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

67194

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
12 Primrose St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 Primrose
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM A. MILLS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	MARRIED

6.(b) Name of ~~husband or~~ wife ADA W. Mills
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 24 - 1869

8. AGE: Years 78 | Months 3 | Days 2. | If less than one day hrs. min.

9. Birthplace MASS. (Town, county, and state)
10. Usual occupation RETIRED
11. Industry or business

MOTHER FATHER
12. Name CHARLES ALLEN MILLS
13. Birthplace MASS.

MOTHER
14. Maiden name ANNA MILLS
15. Birthplace WILMINGTON DEL.

16. Informant MRS WM. A. MILLS.
Address 12 PRIMROSE ST CH. CH. MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-29-47 (month) (day) (year)
Cemetery or crematory ROCK CREEK CEM.
Location WASHINGTON DC

18. Funeral director Jos. Gawler's Sons
Address 1756 Penna. ave. Wash. D.C.

19. 8/27 (Date rec'd by registrar) 1947 Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1947 at 12:50 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1 1946 to Aug 27 1947 and that I last saw ~~him~~ alive on Aug. 26 1947

Immediate cause of death Coronary occlusion with myocardial infarction — DURATION 4 days
Due to Coronary sclerosis — many yrs
Due to
Other conditions Diabetes mellitus — many yrs.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. Maurice Fogg M.D. M. D. or other
Address 1150 Conn Ave. Washington D.C. Date signed Aug 27 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67195

106a

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County: Montg Co
City or town: Gaithersburg, Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 35 yrs
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montg
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route 3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ZERU ALVERDA MOUNT

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: James Mount
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Aug 25th 1873

8. AGE:	Years	Months	Days	If less than one day
1873	73	11	18	....hrs. ....min.

9. Birthplace: Damascus Md,
(Town, county, and state)

10. Usual occupation: House Wife
11. Industry or business: " "

FATHER
12. Name: Luthor Gue
13. Birthplace: Md,

MOTHER
14. Maiden name: Fannie A Warthen
15. Birthplace: Md,

16. Informant: James W. Mount
Address: Gaithersburg, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/47 (month) (day) (year)
Cemetery or crematory: Damascus Cemetery
Location: Damascus, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. Aug 8 1947 (Date rec'd by registrar) Alverda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 3rd 1947 at 1 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 5 - 1947 to Aug - 3 - 1947
and that I last saw h.. alive on Aug - 3 - 1947

Immediate cause of death	DURATION
Acute Bronchitis	4 mo
Due to	
Due to	
Other conditions Chronic debility	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William C. Miller M. D. or coroner
Address: Gaithersburg, Md. Date signed: 8/4/47

VS A15

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67196

Reg. Dist. No. 212

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Montgomery

City or town: Martinsburg Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Martinsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Nelson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	married

6.(b) Name of husband or wife: Chester Nelson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb - 18 - 1890

8. AGE:

Years	Months	Days	If less than one day
57	5	17	..... hrs. ..... min.

9. Birthplace: Martinsburg Md.

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER

12. Name: Charles Pearson

13. Birthplace: Martinsburg

MOTHER

14. Maiden name: Harriet Coleman

15. Birthplace: Louise County Virginia

16. Informant: Mrs. Rosey

Address: Dickerson Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6 1947 (month) (day) (year)

Cemetery or crematory: Martinsburg Maryland

Location: Near Dickerson

18. Funeral director: (Lewis H. Dawson)

Address: Poolesville Md.

19. Aug 6 (Date rec'd by registrar) 1947 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 19 47, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Coronary occlusion	Instantly
Due to	
Due to	
Other conditions: Arteriosclerosis	3 Yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank J. Brosnan M.D.

M. D. or other

Address: Gaithersburg Md. Date signed 8-3-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

56d

67197

Reg. Diat. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Ohio County:

City or town: Cleveland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 13815 Savanah Avenue, East
(If rurol, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

NEMEC, Donald Richard, PVT USMC

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 22, 1929

8. AGE: Years	Months	Days	If less than one day
17	11	0	hrs. min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER 12. Name: Charles NEMEC

13. Birthplace: Ohio

MOTHER 14. Maiden name: Martha Aukschun

15. Birthplace: Germany

16. Informant: mother: Mrs. Martha Evenden

Address: 13815 Savanah Avenue, East Cleveland, Ohio

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-25-47 (month) (day) (year)

Cemetery or crematory: Knollwood Cemetery

Location: Cleveland, Ohio

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N. W., Wash., D.C.

19. 8-22- 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 August 19 47 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-22 7-19 19 47 to 8-22 19 47 and that I last saw him alive on 8-22 19 47

Immediate cause of death	DURATION
Respiratory Failure	1 days
Due to Cerebral Edema	3
Due to Brain Tumor (Ependymoma, right lateral ventricle (benign))	3 mos.?
Other conditions	

(Operation was performed within 3 months of death)

Major findings of operations: Ependymoma, benign, right lateral ventricle Date of op. 18 Aug 47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of Injury: Injured at work?

23. SIGNATURE: Edgar N. Weaver
Edgar N. WEAVER, Lt. (jg) MC USNR

Address: USNH Bethesda, Md. Date signed: 8-22-47

67198

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine years

Hospital, Institution, or street address where death occurred: 603 Flower Ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 603 Flower Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Randolph Newman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, Married, Widowed, or Divorced
male	white	married.

6.(b) Name of husband or wife: Lulu Bell Newman

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): March 15, 1867

8. AGE: Years: 80 Months: 5 Days: 3 If less than one day: ..... hrs. ..... min.

9. Birthplace: Fairfax, Virginia (Town, county, and state)

10. Usual occupation: Time Keeper - retired

11. Industry or business: Govt Printing Office

FATHER — 12. Name: John Newman

FATHER — 13. Birthplace: Fairfax, Va.

MOTHER — 14. Maiden name: Annie E. Stelles

MOTHER — 15. Birthplace: Fairfax, Va.

16. Informant: Mrs. Catherine Koundouriotis

Address: 603 Flower Ave Takoma Park

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1947 (month) (day) (year)

Cemetery or crematory: Geo. Wash. Memorial Cemetery

Location: Prince George Co. Md.

18. Funeral director: Deal Funeral Home

Address: 4812 Ga ave. N.W.

19. Aug 19 1947 (Date rec'd by registrar) J. Theta Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1947 at 9 50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 11 1947 to Aug 18 1947 and that I last saw him alive on August 11 1947

	DURATION
Immediate cause of death: Pulmonary Hemorrhage	Minutes
Due to: Pulmonary Tuberculosis	25 yrs.
Due to:	
Other conditions: Chronic Sinusitis	?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harold R Kelly M.D.

M. D. or other

Address: 805 Carroll Ave Tak. Pk. Date signed: 8-19-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67199

13/a

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Mont A

City or town Olney - Mont Co Gen Hosp - (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, Institution, or street address where death occurred: Mont Co Gen Hosp - Olney Md

How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Mont -

City or town Rockville R 3 (If outside city or town limits, write RURAL and give nearest town)

Street No. Norwood (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Blanche V Nicholson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife nb

6.(c) If alive, give age — years

7. Birth data of deceased (mo., day, yr.) Jan 23 1887

8. AGE: Years 60 | Months 6 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER — 12. Name Williams + Nicholson

FATHER — 13. Birthplace Montgomery Co Md

MOTHER — 14. Maiden name Catalen Young

MOTHER — 15. Birthplace Montgomery Co Md

16. Informant Mrs Large + Johnson

Address Norwood Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 3 1947 (month) (day) (year)

Cemetery or crematory Sts Johns

Location Olney Maryland

18. Funeral director Roland W Barber

Address Laytonsville Md

19. 8-4-1947 (Date rec'd by registrar) Gertrude B. Fowler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1947 at 2:35 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1945 to Aug 3 1947

and that I last saw h[illegible] alive on August 3 1947

Immediate cause of death	DURATION
Cardio-Renal disease -	15 mo
Due to Thrombosis of Mesent. Arteries	
Due to	
Other conditions Chronic Cholecystitis with stone (Include pregnancy within 3 months of death)	12 yrs

Major findings of operations

Data of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Elias B Tomlinson M. D. or Other

Address Sandy Spring Md Date signed

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07200

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 wks.
Hospital, institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 3 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County D. C.
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. Shoreham Hotel, 2500 Calvert NW
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME MARY CRADDOCK PALMER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Ray Palmer
6.(c) If alive, give age Dec. years
7. Birth date of deceased (mo., day, yr.) November 2, 1863

8. AGE: Years	Months	Days	If less than one day
83	9	3	hrs. min.

9. Birthplace Mexico, Missouri (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business None

FATHER
12. Name Samuel Craddock
13. Birthplace Kentucky

MOTHER
14. Maiden name Mary Wilcox
15. Birthplace Mexico, Missouri

16. Informant Dr. Charles R. Halley
Address 18 E. Bradley Lane, Bethesda, Md.

17. Burial-transit (Burial, cremation, or removal. Which?) Date thereof Aug. 5, 1947 (month) (day) (year)
Cemetery or crematory Oak Wood Cemetery
Location Macon, Missouri

18. Funeral director Wm. Reuben Rumphrey
Address Bethesda, Maryland

19. 8/5 1947 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Aug 1947 at 7:52 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 July 1947 to 5 Aug 1947 and that I last saw her alive on 4 Aug 47 19

	DURATION
Immediate cause of death Carcinomatosis	
Due to Carcinoma of female ute.	
Due to	
Other conditions Congestive heart failure	

(Include pregnancy within 3 months of death)

Major findings of operations 0
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph W. Cooch M. D. or other
Address 1726 Eye St. NW, Washington D.C. Date signed 5 Aug 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a 8 67201

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14½ hours

Hospital, Institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 14½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 822 9th Street, Northwest

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

(Peed) PEED, Claudius Benjamin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Maude Peed

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 5 February 1893

8. AGE: Years	Months	Days	If less than one day
54	6	18	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER — 12. Name: Claudius B. Peed

13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Wife: Mrs. Maude Peed

Address: 822 9th St., NW, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-47 (month) (day) (year)

Cemetery or crematory: Oak Grove

Location: Portsmouth, Va.

18. Funeral director: W. W. CHAMBERS CO.

Address: 517 11th St., SE, Washington, D.C.

19. 8-23 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 23 August 19 47 at 12:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-22- 19 47 to 8-23- 19 47 and that I last saw h... im... alive on 8-23- 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertensive Heart Disease	
Due to: Generalized Arteriosclerosis	

Other conditions: Arteriolosclerosis, Nephritic Chronic Myocarditis, Auricular Fibrilliation

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Refused by Next of Kin.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: J. B. Bryan J. B. BRYAN, LTJG MC USNR (M. D. or other)

Address: USNH, Bethesda, Md. Date signed: 8-23-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

8/27/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52 & A

67202

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days 10 Hours

Hospital, Institution, or street address where death occurred:
Suburban Hospital

How long in hospital or Institution? 28 days 10 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice M- Ploutz

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife Samuel H Ploutz
Deceased 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 16 1878

8. AGE: Years	Months	Days	If less than one day
69	6	29	____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name George W. Biddinger
13. Birthplace Maryland

MOTHER
14. Maiden name Jeanette Bitler
15. Birthplace Maryland

16. Informant E. L. Rippeon (son)
Address Rockville Md. Rt 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 17 1947 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location Wy. Liberty

18. Funeral director L. C. Barton

Address Walkersville Md.

19. 8/15 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1947, at 4:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1947 to August 15 1947 and that I last saw her alive on August 15 1947

Immediate cause of death	DURATION
Carcinoma of bladder	one year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of bladder. Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ephraim Sweeney M. D. or other

Address Suburban Hosp. Md. Date signed 8-15-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Geo. E. Rocks

67203

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

Reg. Diat. No. 223

F

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 hrs

Hospital, Institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution? 8 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3945 Conn. Ave N.W. Apt 205

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Miss May Phenix

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1886

8. AGE: Years	Months	Days	If less than one day
61	2	5	hrs. min.

9. Birthplace: Kansas (Town, county, and state)

10. Usual occupation: School teacher (Retired)

11. Industry or business:

FATHER — 12. Name: Vinton Phenix

13. Birthplace: Indiana

MOTHER — 14. Maiden name: Annie Rizer

15. Birthplace: Cumberland, Md.

16. Informant: Sanitarium Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Greeley Colorado

18. Funeral director: Arthur Fuller

Address: 254 Carroll St. Takoma Park, D.C.

19. Aug 28 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1947 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1947, to Aug. 27 1947 and that I last saw h... alive on Aug. 27 1947

	DURATION
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Arteriosclerotic Heart disease	years
Due to:	
Other conditions: Congestive Heart failure	hours

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: DeVon K. Mader M. D. or other

Address: Takoma Park, Md. Date signed 8-27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Copy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

47C

67294

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 days

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 704 5th Street, Southeast

(If rural, give LOCATION)

2.(a) If veteran, name war: WW I ✓

3.(a) FULL NAME: QUEEN, John

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	widowered

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 15 December 1886

8. AGE: Years	Months	Days	If less than one day
60	8	2	hrs. min.

9. Birthplace: Washington, D. C. (Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: Navy Department

FATHER — 12. Name: Edward Queen

13. Birthplace: Maryland, dec.

MOTHER — 14. Maiden name: Alice Henderson

15. Birthplace: Maryland, dec.

16. Informant: Daughter: Miss Naomi Queen

Address: 704 5th St., SE, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: Barnes and Matthews

Address: 614 4th St., SE, Washington, D. C.

19. Aug. 18 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 17 August 19 47 at 1:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6- 19 47 to 8-17- 19 47 and that I last saw him alive on 8-17- 19 47

Immediate cause of death	DURATION
Carcinoma of the Bronchus with Metastases	6 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Carcinoma of Bronchus & metastases.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S F Kaufman S.F.KAUFMAN, LTJG MC USNR M. D. or other

Address: USNH, Bethesda, Md. Date signed: 8-18-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e X

67205

CERTIFICATE OF DEATH

Reg. Diat. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg Route
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dow Clara Virginia Randolph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Married

6.(b) Name of husband or wife Walter Randolph
6.(c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) Nov 27 1918

8. AGE: Years	Months	Days	If less than one day
28	9	3	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business Home

FATHER
12. Name Oscar Chase
13. Birthplace Maryland

MOTHER
14. Maiden name Sarah Chase
15. Birthplace Maryland

16. Informant Sarah Chase
Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2 1947 (month) (day) (year)
Cemetery or crematory John Wesley Rocky Hill Meth
Location Montgomery Co Md
18. Funeral director C W Barlow
Address Laytonsville Md

19. Sept 2 1947 (Date rec'd by registrar) Alvada L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947, at 5:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1947, to August 30, 1947 and that I last saw her alive on August 30 1947

Immediate cause of death	DURATION
Generalized carcinoma,	1 year.
origin undetermined.	
Due to Emaciation, Vomiting, weakness,	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James D. Kerr M.D.
M. D. or other
Address Darnestown, Md Date signed 9/2/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67206

Reg. Dist. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville RFD #3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 years

Hospital, institution, or street address where death occurred: Rockville, RFD #3, Maryland

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville RFD #3

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RFD #3

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: JOHN M. REDPATH

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Jessica A. Redpath

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): January 31, 1879

8. AGE: Years	Months	Days	If less than one day
68	6	10	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Farming

FATHER

12. Name: Frank Redpath

13. Birthplace: Pennsylvania

MOTHER

14. Maiden name: Ann Martin

15. Birthplace: Pennsylvania

16. Informant: Mrs. Jessica A. Redpath - Wife

Address: Rockville, RFD #3, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 14, 1947 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Pumphrey

Address: Rockville, Maryland

19. 8/13 1947 (Date rec'd by registrar) E. P. Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 11 1947 at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h ..... alive on ..... 19.....

Immediate cause of death	DURATION
DEP. MED. EXAM. CASE	
Coronary occulsion	Died
Due to	Suddenly
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Emil G. Bauerfeind Den. Med. Examiner

Address: 7345 Wisconsin Ave. Bethesda, Maryland Date signed: 8/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07207

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186 b

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: The Montgomery County General Hospital Inc.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 750 Fairmont st. N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Webster Rich

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Virginia Rich
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.): March 18, 1910
8. AGE: Years 37 Months 4 Days 18 If less than one day ... hrs. ... min.
9. Birthplace Lent, Virginia (Town, county, and state)
10. Usual occupation Merchant
11. Industry or business
FATHER 12. Name Charles Rich
13. Birthplace Fort Doyle, Virginia
MOTHER 14. Maiden name Sallie Beasley
15. Birthplace Sparta, Virginia
16. Informant Hospital records.
Address
17. Removal (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory
Location Washington D.C.
18. Funeral director W. Ernest Jarvis
Address 1432 You St. N.W.
19. Aug 6 1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947, at 11:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1947, to August 6 1947 and that I last saw him alive on August 6 1947

	DURATION
Immediate cause of death: Pulmonary Embolus	5 min
Due to: Fracture of left femur & right tibia & fibula	4 days
Due to:	

Other conditions: Injured while moving a house. The building fell & both legs were caught (10/1/47 os.)
(Include pregnancy within 3 months of death)
Major findings of operations: Traction for fracture of left femur, fixed right. Date of op. 8/6/47
Autopsy results: None Tibia & Fibula
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/2/47
Where did injury occur? Ivy Hill Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury Accidental Injured at work? yes

23. SIGNATURE J.M.B. Opp Pathologist M. D. or other
Address Sandy Spring, Md. Date signed 8/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67208

157e

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2610 S. Nash St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: RICHARDSON, Howard

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 22 August 1947

8. AGE: Years	Months	Days	If less than one day
0	0	4	hrs. min.

9. Birthplace: Bethesda, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Richardson, Charles Wells
13. Birthplace: Va.

MOTHER
14. Maiden name: Peterson, Madeline Cecelia
15. Birthplace: Va.

16. Informant: father: Lt. Charles W. Richardson USN
Address: 2610 S. Nash St., Arlington, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 8-27-47 (month) (day) (year)

Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W. Wash., D.C.

19. Aug. 26 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 August 1947, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 August 1947, to 26 August 1947, and that I last saw him alive on 26 August 1947

Immediate cause of death: Congenital Heart (Patent Ductus arteriosus) — DURATION:

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: Same (Confirmed Clinical Diag.) Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: PAUL PETERSON, Capt. MC USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

6/29/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67209

922

CERTIFICATE OF DEATH

Reg. Diat. No. 213

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred:
218 W. Montgomery Avenue

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 218 W. Montgomery Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: WALLACE ENGLEBERT RICKETTS

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma L. Ricketts

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1862

8. AGE: Years	Months	Days	If less than one day
84	9	1	...hrs. ...min.

9. Birthplace: Middlebrook, Maryland (Town, county, and state)

10. Usual occupation: Retired Auto Dealer

11. Industry or business: Auto Dealer

FATHER — 12. Name: Zadoc B. Ricketts

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Serene Amanda Bean

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. G. V. Hartley

Address: Rockville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10, 1947 (month) (day) (year)

Cemetery or crematory: Rockville Union Cemetery

Location: Rockville, Maryland

18. Funeral director: Wm. Reuben Thompson

Address: Rockville, Maryland

19. 8/10 1947 (Date rec'd by registrar) E P Thompson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 8 1947, at 6:30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 1938 to August 8 1947

and that I last saw h... alive on August 7 1947

Immediate cause of death	DURATION
Congestive heart failure	4 days
Due to: Chronic valvular heart disease	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: G. V. Hartley M.D
M. D. or other

Address: Rockville, Md. Date signed 8/10/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67212

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 13 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: N.Y. County:

City or town: York Town Heights
(If outside city or town limits, write RURAL and give nearest town)

Street No. French Hill Farm, Baldwin Road
(If rural, give LOCATION)

2.(a) If veteran, name war: WWI

3.(a) FULL NAME: ROBERTS, Ora Singleton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 30 June 1888

8. AGE: Years	Months	Days	If less than one day
59	1	29	hrs. min.

9. Birthplace: Penn.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: ROBERTS, Charles Wesley dec
13. Birthplace: Pa.

MOTHER
14. Maiden name: CURRY, Carry dec.
15. Birthplace: Pa.

16. Informant: dauther: Mrs. Mary Anderson
Address: French Hill Farm, Bladwin Road, York Town Heights, N.Y.

17. removal (Burial, cremation, or removal. Which?) Date thereof: 8 24 47 (month) (day) (year)

Cemetery or crematory:

Location: Newport, R.I.

18. Funeral director: W. W. CHAMBERS
Address: 1400 Chapin St., N. W., Wash., D.C.

19. 8-29 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 August 1947 at 9:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 June 1947 to 29 Aug 1947 and that I last saw h... im alive on 29 August 1947

Immediate cause of death	DURATION
Bronchogenic carcinoma	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Andrew M. Margileth M.D.

23. SIGNATURE: A.M. MARGILETH, Lt. JG MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-29-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

9/5/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67213

462

SB

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4mos 11days

Hospital, institution, or street address where death occurred:
USNH, NNMC, Bethesda, 14, Maryland

How long in hospital or institution? 4 mos 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3848 Porter St., N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW1

3. (a) FULL NAME

George Washington ROGERS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Irene Rogers

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8, 1891

8. AGE: Years	Months	Days	If less than one day
56	0	1	..... hrs. ..... min.

9. Birthplace: Connecticut
(Town, county, and state)

10. Usual occupation: Attorney

11. Industry or business: US Government

FATHER
12. Name: Thomas Rogers
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Drysdale
15. Birthplace: Ireland

16. Informant: Wife: Mrs. Irene Rogers
Address: 3848 Porter St., NW, Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-13-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

18. Funeral director: W. W. Chambers Co. S.J.K.
Address: 1400 Chapin St., NW, Washington, D.C.

19. 8-10-47 19..... Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9 August 19 47 at 9:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 March 1947, to 9 August 1947 and that I last saw him alive on 9 August 1947

Immediate cause of death	DURATION
Carcinoma of the Esophagus with Metastases	8 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Gastrostomy revealed Carcinoma at Esophago-Cardiac end of stomach. Date of op. 15 April 47

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Seymour Fred Kaufman M. D. or other

Address: USNH, NNMC, Bethesda, Md. Date signed 8-10-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct and complete as is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

8/14/47

Evidence for the change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

67214

FILM No. G 112 SEP 8 1947

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 100 Balt. Avenue.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: MARY L. SANDERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: William Saunders 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 21 1855

8. AGE: Years 92 Months 18 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace: Pomfret, Charles Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Unknown Wm. F. Dennant
13. Birthplace: Pomfret, Chas. Co. Md. (Md)

MOTHER — 14. Maiden name: Unknown Mary L. Green
15. Birthplace: Pomfret, Charles Co. Md.

16. Informant: Eulogy L. George
Address: 100 Baltimore Ave Takoma

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 31, 1947 (month) (day) (year)
Cemetery or crematory: St. Joseph's Cemetery
Location: Pomfert, Maryland

18. Funeral director: James E. Nolan, Inc.
Address: 317 Penna. Ave. S.E. Wash. D.C.

19. 8/31 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 31 1947, at 4:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to Aug 31 1947 and that I last saw h.. alive on Aug 31 1947

Immediate cause of death	DURATION
Congestive Heart Failure	2 wks.
Due to: Arteriosclerosis	15 yr.
Due to: Hypoproteinemia	
Other conditions: Hypoproteinemia. Apeptic Anemia.	3 mos ?

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James E. Nolan M.D
M. D. or other
Address: 1150 Conn Ave NW Wash DC Date signed 8/31/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

67215

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4521 36th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW1 & 2

3.(a) FULL NAME: SAUNDERS, Norman Louis, Cdr. HC USN Ret.Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Hazel W. Saunders
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11 December 1886

8. AGE: Years	Months	Days	If less than one day
60	8	15	hrs. min.

9. Birthplace: Michigan
(Town, county, and state)
10. Usual occupation: Retired Navy
11. Industry or business:

FATHER
12. Name: Louis Saunders dec
13. Birthplace: Michigan

MOTHER
14. Maiden name: Sarah Ball dec
15. Birthplace: Michigan

16. Informant: wife: Mrs. Hazel W. Saunders
Address: 4521 36th St., N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 8-29-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Deal Funeral Home E. J. Deal
Address: 4812 Georgia Avenue, N.W., Wash., D.C.

19. 8-27 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

8/28/47

MEDICAL CERTIFICATION

20. DATE OF DEATH: 26 August 1947 at 10:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 26 August 1947 to 26 August 1947 and that I last saw him alive on 26 August 1947

	DURATION
Immediate cause of death: MYOCARDIAL INFARCTION	8 HRS.
Due to: CORONARY ARTERY SCLEROSIS	
Due to: GENERALIZED ARTERIO-SCLEROSIS, HYPERTENSION	8 Mo. 2½ yr.
Other conditions: RUPTURED PAPILLARY MUSCLE OF MITRAL VALVE	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: AS ABOVE
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. W. Wainwright MCR USNR
F. E. JARRETT, Cdr. MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 8-27-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

67216

CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH:
County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, institution, or street address where death occurred:
64 Lincoln Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Kensington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 64 Lincoln Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME JOSEPH G. SCHMIDT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Katherine H. Schmidt
6.(c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) April 1, 1873

8. AGE: Years	Months	Days	If less than one day
74	74	4	19 hrs. min.

9. Birthplace New York City, N. Y. (Town, county, and state)
10. Usual occupation D. C. Government Clerk
11. Industry or business Clerical

FATHER
12. Name John Schmidt
13. Birthplace Germany

MOTHER
14. Maiden name Elizabeth Fleck
15. Birthplace Germany

16. Informant Robert J. Schmidt
Address Kensington, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 23, 1947 (month) (day) (year)
Cemetery or crematory Potomac Methodist Church Cem
Location Potomac, Maryland

18. Funeral director Wm. Rawdon Pumphrey
Address Bethesda, Maryland

19. Aug 21 1947 (Date rec'd by registrar) Josephine M. Reiffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/47 19 at 9:30 AM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan '47 19 to 8/20/47 19 and that I last saw h.i.m alive on 8/15/47 19

	DURATION
Immediate cause of death Coronary Occlusion, Acute	4 Hrs.
Due to Arteriosclerosis Generalized	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Donald Allen MD M. D. or other
Address Kensington Md Date signed 8/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

9-45a

17210

Reg. Dist. No. 2 18

1. PLACE OF DEATH:
County Montgomery
City or town Rural - Brookeville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State none known County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY ALICE SCHOOLER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Either 1858 or 1859 Aug 6

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
89 or 88	0	24		

9. Birthplace Fairfax Va.
(Town, county, and state)
10. Usual occupation none
11. Industry or business —
FATHER 12. Name no record.
13. Birthplace
MOTHER 14. Maiden name no record.
15. Birthplace
16. Informant Montgomery County Welfare Board.
Address Rockville Md.
17. Burial Date thereof Sept 2. 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rockville Md
Location Montgomery Co. Md
18. Funeral director Roy W Barber
Address Rockville Md
19. 9/2 47 L. D. Bell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1947 at 9:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to August 30 1947 and that I last saw her alive on August 26 1947

Immediate cause of death	DURATION
Acute coronary occlusion	
Due to Generalized Arteriosclerosis	years
Due to Senility	years.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury Injured at work?

23. SIGNATURE Richard A Yates M.D.
M. D. or other
Address RFD #3 Rockville Date signed 8/30/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

67211

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery County

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? Since birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 935 - Bonifant St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Boy Leo Skandies

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-20-47

8. AGE: Years	Months	Days	If less than one day
Not known			14 hrs. 13 min.

9. Birthplace: Bethesda, Montg. Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business —

FATHER — 12. Name: Leo Skandies

13. Birthplace: Baltimore, Md

MOTHER — 14. Maiden name: Helen Magill

15. Birthplace: Baltimore Md

16. Informant: Leo Skandies

Address: Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 23 1947 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Md.

18. Funeral director: Warner E. Pumphrey

Address: 8434 Georgia Ave, Silver Spring Md.

19. 8/22/1947 (Date rec'd by registrar) Wm E Foles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 21 19 47 at 1 56 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 19 47 to Aug 21 19 47

and that I last saw him alive on Aug 20 19 47

Immediate cause of death	DURATION
Respiration ceased.	
Due to Lack of viability.	
premature baby	
Due to 6½ to pregnancy.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. Knapp. M. D. or other

Address: 1801 - K St. N.W. Date signed: Aug 21, 47.

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67218

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? seven days
Hospital, institution, or street address where death occurred:
USNH Bethesda, Md.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Virginia County: Arlington
City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1903 North Quebec Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: SHREVE, Lewis Ellsworth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Elsie Shreve
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 7 August 1890

8. AGE: Years	Months	Days	If less than one day
57	0	8	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: Mr. Robert Shreve
13. Birthplace: Virginia, dec

MOTHER
14. Maiden name: Anna Donaldson
15. Birthplace: Washington, D. C., dec.

16. Informant: Wife: Mrs. Elsie Shreve
Address: 1903 North Quebec St., Arlington, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-19-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: C. J. Ives Funeral Home C.J.I.
Address: 2887 Wilson Blvd., Arlington, Va.

19. 8-16-47 (Date rec'd by registrar) 19.....
Mary Charlotte Smith
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG 15 1947 19.... at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-8- 1947 to 8-15- 1947 and that I last saw him alive on 8-15- 1947

Immediate cause of death	DURATION
Uremia	1 mo.
Severe acidosis	2 wks.
Due to Hypertensive Heart	
disease with failure	6 yrs.
Due to Renal failure - Chronic	
glomerulonephritis	10 yrs.
Other conditions Acidosis; hypoproteinemia	5 yrs
anemia.	

(Include pregnancy within 3 months of death)

Major findings of operations: none performed Date of op.....
Autopsy results: none performed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Hugh Stevens Jr. M.D. or other
Address: NNMC / Bethesda Md Date signed: 8-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

07217

CERTIFICATE OF DEATH

Reg. Diat. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Dickinsons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs.

Hospital, institution, or street address where death occurred:

HOME

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty.

City or town Dickerson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Anna V. Sigafoose

3.(b) Social Security Number None -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles H. Sigafoose

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1879

8. AGE: Years	Months	Days	If less than one day
68	9	14	....hrs. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Kent

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden name Mary Hughes

15. Birthplace Maryland

16. Informant Chas. H. Sigafoose

Address Dickerson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-16-47 (month) (day) (year)

Cemetery or crematory Loudoun Park Cem.

Location Baltimore, Md.

18. Funeral director Wm. B. Kilton

Address Barnesville, Md.

19. Aug. 14 1947 (Date rec'd by registrar) Mrs. C.C. Hilton Registrar Dep. Reg. Montgomery Co., Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14, 1947, at 4:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1947, to Aug 14 1947

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cerebral accident	1 day
Due to Generalized arteriosclerosis	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE E. P. Davenport M.D.

Address Brookeville, Md. Date signed 8/14/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67219

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

S

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 2 d a ys

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1741 S Street, N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW1

3.(a) FULL NAME: SMITH, JohnTabb

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	married

6.(b) Name of husband or wife: Lottie B. Smith

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 13, 1892

8. AGE: Years	Months	Days	If less than one day
54	8	23	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business:

FATHER
12. Name: Smith, Daniel dec.
13. Birthplace: Va.

MOTHER
14. Maiden name: TABB, Bell dec.
15. Birthplace: Va.

16. Informant: wife: Mrs. Lottie B. Smith
Address: 1741 S Street, N. W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11, 1947 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis

Address: 1432 U St., N.W., Wash., D.C.

19. 8-7- 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 August 19 47 at 7:20P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 Aug. 19 47 to 6 Aug. 19 47 and that I last saw h im alive on 6 August 19 47

Immediate cause of death	DURATION
Cerebrovascular Occlusion	4 days
Due to: Hypertensive Cardiovascular Disease	7 yrs (?)
Due to:	
Other conditions: Diabetes Mellitus	2 weeks (?)
Lobular Pneumonia	2 days
Chronic Cystitis	1 yr (?)

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Jesse R Wilson Jr Lt jg MC USNR
Jesse R. WILSON, Jr., Lt. (jg) MC USNR
M. D. or other

Address: USNH Bethesda, Md. Date signed: 8-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15M

8/1 3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67220

Reg. Diat. No. 714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH

County: Montgomery

City or town: Laytonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Laytonsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War I.

3. (a) FULL NAME Mahlon Sycengas Smith

3. (b) Social Security Number 212-14-5724

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5/28/1892

8. AGE: Years: 55 Months: 3 Days: 25 If less than one day: ..... hrs. ..... min.

9. Birthplace: Laytonsville Montg Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Pete Smith

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Jessica Smith

MOTHER — 15. Birthplace: Md

16. Informant: Mrs Elvince Turner

Address: Kensington Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 25 1947 (month) (day) (year)

Cemetery or crematory: Layhill Union Cem.

Location: Layhill Maryland

18. Funeral director: Warner E. Humphreys

Address: Silver Spring, Md

19. Aug 24 1947 (Date rec'd by registrar) Josephine M Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/23/1947 at 7 A M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 6/1/1947 to 8/23/1947 and that I last saw him alive on 8/21/1947

Immediate cause of death	DURATION
Acute cardiac dilatation	5 m
Due to: Chronic Myocarditis	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Laytonsville, Md. Date signed: 8/23/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

137 BC

67221

Reg. Dist. No. 193

1. PLACE OF DEATH:

County: Montgomery Co.

City or town: Sandy Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mont. Co. Gen. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 Pitcher St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: PAUL SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	

6.(b) Name of husband or wife: Bernice Smith

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): Jan. 12 1712

8. AGE: Years: 35 Months: 7 Days: 10 If less than one day: hrs. min.

9. Birthplace: Connellsville Pa. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Walter Smith

13. Birthplace: Howard Co.

MOTHER — 14. Maiden name: Sodetie Bond

15. Birthplace: Howard Co.

16. Informant: Mrs. Walter Smith

Address: Cooksville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 19 1947 (month) (day) (year)

Cemetery or crematory: Bush Park

Location: Near Cooksville Howard Co.

18. Funeral director: H. M. Brayden

Address:

19. (Date rec'd by registrar) 8/19/1947 E. Baul Spencer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 17 19 47 at 4:34 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Pulmonary Hemorrhage	?
Due to: Pulmonary Tuberculosis	?
Due to:	
Other conditions: None	

C.P.T. (Include pregnancy within 3 months of death)

Major findings of operations: O.F.

Deputy Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Medical

Accident, suicide, or homicide: Date of EXAMINER

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured while ASST. Deputy Medical EXAMINER

23. SIGNATURE: Nellie E. DeLaute M.D. M. D. or other

Address: 4828 Chevy Chase DR Chevy Chase 15, Md. Date signed: 8/17/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

67222

CERTIFICATE OF DEATH

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred: 7330 Piney Branch Road.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7330 Piney Branch Road

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish American War.

3.(a) FULL NAME John L. Spence

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife Eva A. Spence

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mar 10, 1880

8. AGE: Years 67 | Months 5 | Days 20 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual occupation Retired Penna. R.R.

11. Industry or business

FATHER 12. Name John H. Spence

13. Birthplace Baltimore Md.

MOTHER 14. Maiden name Lola

15. Birthplace Not known

16. Informant Mrs. Eva A. Spence

Address 7330 Piney Branch Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 22 1947 (month). (day). (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington Va.

18. Funeral director H. Struhsaker Mortuary

Address 754 Eye St. N.W.

19. Aug 21 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20, 1947, at 9:35 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20, 1947, to ..... 19..

and that I last saw him alive on Aug 20, 1947

Immediate cause of death ..... DURATION

Coronary thrombosis 1½ hr.

Due to arteriosclerosis Indefinite

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

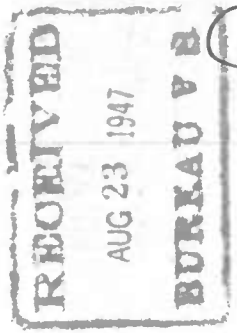
Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. B. Smith M.D. M. D. or other

Address 6911 Sligo St. N.W. Date signed 8/20/47

Permission to sign this certificate was given by Dr. Broschart, Coroner.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1110

10939 67223

Reg. Dist. No. 316

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #3 Bradley Blvd. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Anna Maria Strunk

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Henry
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 10, 1868

8. AGE: Years 79 | Months 1 | Days 25 | If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Bernard Thiebes
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name:
MOTHER 15. Birthplace: Germany
16. Informant: Peter Strunk (son) Address: same
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/6/47 (month) (day) (year)
Cemetery or crematory: Rock Creek Cem
Location: Md.
18. Funeral director: H. N. Chambers Co
Address: 1400 Chapin St. N.W. Wash D.C.
19. 8/4 19 47 (Date rec'd by registrar) Wm E. Jordan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 19 47 at 2:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 19 47, to August 4 19 47 and that I last saw h[illegible] alive on August 4 19 47

Immediate cause of death	DURATION
Pulmonary thrombus and embolus	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: Pulmonary thrombus and embolus.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: DeWitt E. Lawler M.D. (M. D. or other)
Address: 4828 Chevy Chase DR Chevy Chase 15, Md. Date signed 8/4/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11192

67224

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122b

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4300 East-West Highway
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME: Mrs. Anna A. Taintor

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) ~~Single, married, widowed, or divorced~~
Female	white	widow

6.(b) Name of husband or wife: Frank A. Taintor
6.(c) If alive, give age: dec. years
7. Birth date of deceased (mo., day, yr.): June 11, 1864

8. AGE: Years 83 | Months 2 | Days 19 | If less than one day: — hrs. — min.

9. Birthplace: Vermont (Town, county, and state)
10. Usual occupation: none
11. Industry or business: HOUSEWIFE

FATHER
12. Name: Samuel Blanchard
13. Birthplace: Vermont

MOTHER
14. Maiden name: Cordelia Bliss
15. Birthplace: Vermont

18. Informant: Mrs. ~~Jam~~ Rhodes daughter
Address: Same

17. Cremation (Burial, cremation, ~~removal~~. Which?) Date thereof: Sept. 3, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Washington, D. C.
18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda 14, Maryland

19. 9/1 1947 (Date rec'd by registrar) Mrs E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: aug 30 1947 at 5.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from aug 25 1947 to aug 30 1947 and that I last saw h.e.r. alive on aug 30 1947

	DURATION
Immediate cause of death: Pneumonia, Bronchial	(9/24/47 as.)
Due to: Debilitated condition	3 days
Due to: Intestinal Obstruction	5 days
Other conditions: Blind (both eyes)	—

(Include pregnancy within 3 months of death)

Major findings of operations: Ileum caught in femoral canal Date of op. aug 29 47
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. B. Ford M.D. M. D. or other
Address: Suburban Hosp. Date signed Aug 30 '47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67225

94a

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months 15 days

Hospital, institution, or street address where death occurred: Wash. San. Hospital

How long in hospital or institution? 6 months 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5127 5th St N.W. Wash. D.C.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Samuel G. Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Melba K. Taylor

Dec 31 1896 6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.): March 3 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	6	21		

9. Birthplace: James Port, Missouri (Town, county, and state)

10. Usual occupation: Meat Merchant (Retired)

11. Industry or business:

FATHER — 12. Name: John P. Taylor

FATHER — 13. Birthplace: Virginia

MOTHER — 14. Maiden name: Mary Sluth

MOTHER — 15. Birthplace: Ohio

16. Informant: Mrs Melba K Taylor

Address: 5127 5th St NW. Wash. D.C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 27 (month) (day) (year)

Cemetery or ~~crematory~~: Cedar Hill

Location: 4000 Suitland Rd. S.E.

18. Funeral director: The S.H. Hines Co

Address: 2901 14th St N.W.

19. Aug 24 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1947 at 5.50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1947 to August 24 1947

and that I last saw him alive on 8-24-47 1947

Immediate cause of death	DURATION
Due to: Perforated Stomach and Generalized Arteriosclerosis	8 hrs 12 yrs
Due to: Terminal Bronchopneumonia	2 days.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Ernest H. Bayliss MD M. D. or other

Address: 8252 Ga Ave Silver Spring Md Date signed 8-24-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1700

07226

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 hours

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital, Bethesda, Maryland

How long in hospital or institution? 36 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: North Dakota County:

City or town: Stanley

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: WW II

3.(a) FULL NAME: TENBORG, Francis Gerald

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 26 September 1927

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
19	11	5		

9. Birthplace: North Dakota (Town, county, and state)

10. Usual occupation: U. S. Navy

11. Industry or business:

FATHER

12. Name: Gerald Tenborg

13. Birthplace: North Dakota

MOTHER

14. Maiden name: Esther Hellum

15. Birthplace: Norway

16. Informant: U. S. Naval Records

Address:

17. removal (Burial, cremation, or removal. Which?) Date thereof 9 (month) 2 (day) 47 (year)

Cemetery or crematory:

Location: Stanley, North Dakota

18. Funeral director: W. W. Chambers Co. K.M.S.

Address: 1400 Chapin Street, NW, Washington, D.C.

19. 9-1-47 (Date rec'd by registrar) 19

Mary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 August 19 47 at 6:20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. med Exam Case 19 to 19

and that I last saw h alive on 19

Immediate cause of death — DURATION

Lobar pneumonia — 1½ days

Due to: Compound fracture of left femur & left tibia & fibulae — 2 days

Due to: (accidental)

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 8-26-47

Where did injury occur? Laurel (City or town) R 9. (County) md (State)

Injured at home, farm, industry, public place (where?): highway

Means of injury: struck by auto Injured at work? no

23. SIGNATURE: Frank J. Brockett M. D.

Dep. med. Exam M. D. or other

Address: Gaithersburg md Date signed 9-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

9/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67227

48at

Reg. Dist. No. 514

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Usual~~ street address where death occurred:
8816 Flower Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8816 Flower Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME
IDA TESTER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~XXX~~ John W.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 19th. 1889

8. AGE: Years	Months	Days	If less than one day
58	0	12	..... hrs. ..... min.

9. Birthplace Grayson Co. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Henry Davis
13. Birthplace N. C.
MOTHER 14. Maiden name Betsy Davis
15. Birthplace N. C.
16. Informant Mr. John W. Tester
Address 8816 Flower Ave. Silver Spg.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 3rd. 1947 (month) (day) (year)
Cemetery or ~~XXXX~~ Fort Lincoln
Location Prince Georges Co. Md.
18. Funeral director Warner C. Pumphrey
Address Silver Spring, Md.
19. Sept 2 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1947 at 10:45 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1947, to Aug 31 1947
and that I last saw her alive on Aug. 31 1947

	DURATION
Immediate cause of death Cardiac Failure	24 hrs
Due to Carcinoma of cervix	5 yrs.
Due to Chronic nephritis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank G. Zack M.D. M.D. or other
Address 8248 Ga Ave Silver Spring, Md. Date signed 9-2-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 C

67228

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~XXXXXXXXX~~ street address where death occurred:
19 Boyd Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 Boyd Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: JAMES A. THOMAS

3.(b) Social Security Number: 578-32-2836

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife: X
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 29th. 1894

8. AGE: Years	Months	Days	If less than one day
53	4	29	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Walter Reed Gen'l Hospital
FATHER 12. Name: James E. Thomas
13. Birthplace: Wash. D. C.
MOTHER 14. Maiden name: Katie E. Kelly
15. Birthplace: Wash. D. C.
16. Informant: Mrs. Lillian T. Fowler
Address: 19 Boyd Ave. Takoma Park. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30th. 1947 (month) (day) (year)
Cemetery or ~~XXXXX~~: St. John's
Location: Forest Glen, Md.
18. Funeral director: Waver & Compahony
Address: Silver Spring, Md.
19. Aug 29 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1947, at 3:17 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 to 19
and that I last saw h alive on Exam case 19

Immediate cause of death	DURATION
Hemorrhage due to	duration
bullet wound in left	unknown
Due to: skull	
(Suicide)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 8-28-47
Where did injury occur? Takoma Park (City or town) Monty (County) Md (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: 38 cal pistol Injured at work? no

23. SIGNATURE: Frank J. Brockhurst M.D.
Dep. Med. Exam. M. D. or other
Address: Gaithersburg Md Date signed: 8-28-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of birther age is shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67229

94a

Reg. Dist. No. 3/6

File No. G 112 OCT 8 1947

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months
Hospital, institution, or street address where death occurred:
Apt. #1, 4829 Chevy Chase Drive,
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. Apt. #1, 4829 Chevy Chase
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME: EASTWOOD P. THOMPSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Saddie E. Thompson
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.): August 2, 1869 78

8. AGE: Years	Months	Days	If less than one day
~~78~~ 69 ~~78~~	0	27	— hrs. — min.

9. Birthplace: Easthampton, Massachusetts (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Lawyer

FATHER
12. Name: John P. Thompson
13. Birthplace: Veazy, Maine

MOTHER
14. Maiden name: Caroline Eastwood
15. Birthplace: Maine

16. Informant: Mrs. Saddie E. Thompson (wife)
Address: Chevy Chase, Maryland

17. Burial-Transit (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1947 (month) (day) (year)
Cemetery or crematory: Bridge Street Cemetery
Location: Northampton, Massachusetts

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. 8/30/47 (Date rec'd by registrar) Wm E Foley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th, 1947 at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1946 to Aug 29 1947 and that I last saw h[illegible] on March 5 1947

Immediate cause of death	DURATION
Coronary Thrombosis	Instant
Due to Arteriosclerosis - several yrs. duration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D.
Address: 8016 Old Georgetown Rd., Bethesda 14, Maryland Date signed 8/29/47

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

67230

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Rockville, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery

City or town Rural Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R F D 4

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Linda L Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 2-1947

8. AGE: Years | Months | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Rockville, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James W Thompson

13. Birthplace Maryland

MOTHER 14. Maiden name Edith Redman

15. Birthplace Maryland

16. Informant James W Thompson

Address Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 10/47 (month) (day) (year)

Cemetery or crematory Methodist

Location Dickerson, Md

18. Funeral director William B Dillon

Address Barnesville, Md

19. Aug 9 1947 Claude L Cooke

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1947, at 10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1947, to Aug 9 1947

and that I last saw h.. alive on Aug 9 1947

Immediate cause of death	DURATION
Premature 6 Mos.	
Due to same	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mary Sturbridge M.D. M. D. or other

Address Gaithersburg Date signed Aug 9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

67231

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, institution, or street address where death occurred:
6924 Fairfax Road
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County: D. C.
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3130 Wisconsin Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: JOHN F. TINSMAN

3.(b) Social Security Number: 140-07-8570

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Alice R. Tinsman
6.(c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): April 8, 1877
8. AGE: Years: 70 Months: 3 Days: 25 If less than one day: hrs. min.
9. Birthplace: Bevidere, New Jersey (Town, county, and state)
10. Usual occupation: Retired Salesman
11. Industry or business:
FATHER 12. Name: William H. Tinsman
13. Birthplace: Unknown
MOTHER 14. Maiden name: Molly Bennett
15. Birthplace: Unknown
16. Informant: Mrs. Ruth T. Konnialky
Address: Bethesda, Maryland
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: August 5, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Crematory
Location: Washington, D. C.
18. Funeral director: Mrs Reuben Pumphrey
Address: Bethesda, Maryland
19. 8/4 1947 Mr E Jones Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3rd 1947 at 3 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1943 to Aug. 1947; and that I last saw h.e. alive on Aug 3rd 1947

	DURATION
Immediate cause of death: Carcinoma of Bladder	2 years
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles P. Howze, M. D. or other
Address: 1150 Connecticut Ave N.W. Washington, D.C. Date signed: Aug 3-1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67232

74a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
902 Bonifant St.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 902 Bonifant St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME JOHN FRANKLIN TROUPE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ wife: Emily Hey

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18th. 1876

8. AGE: Years	Months	Days	If less than one day
71	5	16	..... hrs. ..... min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Lt. of Guards

11. Industry or business: Fed'l Deposit Ins. Corp.

FATHER
12. Name: John Franklin Troupe, Sr.
13. Birthplace: Penna.

MOTHER
14. Maiden name: Caroline Cheyne
15. Birthplace: Penna.

16. Informant: Mrs. Emily Hey Troupe
Address: 902 Bonifant St. Silver Spring.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-1947 (month) (day) (year)

Cemetery ~~XXXXX~~ Fort Lincoln

Location: Prince Georges Co., Md.

16. Funeral director: Warner E. Pumphrey.

Address: Silver Spring, Md.

19. Aug 4 1947 (Date rec'd by registrar) Josephine M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1947, at 11 P. M.

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from Sept. 1946 to Aug. 2 1947

and that I last saw him alive on Aug. 2 1947

Immediate cause of death	DURATION
Chronic Myelogenous Leukemia	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John E. Emerich M. D.
M. D. or other

Address: 6361 - 14th St. N.W. Date signed: 8/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

159

67233

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Montgomery

City or town Unknown

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Unknown County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Baby boy Unknown

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years | Months | Days | If less than one day

about 7 mo gestation ..... min.

9. Birthplace Unknown

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER

12. Name —

13. Birthplace —

MOTHER

14. Maiden name —

15. Birthplace —

16. Informant Dr. F. J. Brochard

Address Gaithersburg Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/30/47 (month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location Rockville Md

18. Funeral director C. C. Fulton

Address Gaithersburg Md

19 Aug 30 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Unknown about Aug 28 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 Med Exam case 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Unknown	
Found raped in newspaper	
Due to under bridge along creek	
Due to Near Derwood, Md	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Unknown Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Brochard M. D.

Dep. Med. Exam M. D. or other

Address Gaithersburg Md Date signed 8-30-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

67234

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 B

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State District of Columbia County
City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1365 Columbia Road
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME Maude WAUGH, Miss Pearl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 7, 1871

8. AGE: Years	Months	Days	If less than one day
76	3	5	..... hrs. ..... min.

9. Birthplace Tipton, Indiana (Town, county, and state)
10. Usual occupation Piano Teacher
11. Industry or business
FATHER 12. Name Don Waugh
13. Birthplace Indiana
MOTHER 14. Maiden name Alice Elizabeth Grove
15. Birthplace Ohio
16. Informant Records - Washington Sanitarium and Hospital
Address 700 Carroll Avenue, Takoma Park, Maryland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 15 1947 (month) (day) (year)
Cemetery or crematory Re
Location Tipton, Ind.
18. Funeral director The J.H. Hines Co.
Address 3901 14th St N.W. Washington
19. Aug 12 1947 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1947, at 6 54 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 27 1947, to August 12 1947 and that I last saw her alive on August 11 1947

Immediate cause of death	DURATION
Esophageal Varicose Hemorrhage	Terminal
Due to Congestive Cardiac Failure	3 mos
Due to Hypertension	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results X
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Robert A. Hare M.D.
M. D. or other
Address Takoma Park, Md. Date signed 8/12/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

67235

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95C

CERTIFICATE OF DEATH

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Georgia Ave. extended
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: JOHN JOSEPH WEISMAN

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of wife: Mary Agnes
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 6th. 1891

8. AGE: Years	Months	Days	If less than one day
56	5	0	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Restaurant owner
11. Industry or business
FATHER 12. Name: John E. Weisman
13. Birthplace: Germany
MOTHER 14. Maiden name: Nellie O'Kiefe
15. Birthplace: Ireland
16. Informant: Mr. Jack Weiseman
Address: Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8-9-1947 (month) (dny) (year)
Cemetery or crematory: St. Johns
Location: Forest Glen, Montg. Co. Md.
18. Funeral director: Warner Thompson
Address: Silver Spring, Md.
19. 8/9 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6 Aug 1947, at 8:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1946, to 6 Aug 1947 and that I last saw h[illegible] alive on 5 Aug 1947

	DURATION
Immediate cause of death: Cardiac Decompensation	2 mo.
Due to: Auricular Fibrillation	2 mo
Due to: arteriosclerosis, Generalized	?
Due to:	
Other conditions: Hypertension	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William E. Earp, M.D.
M. D. or other
Address: 9006 Colesville Rd. Silver Spring Date signed: 6 Aug 1947

BIRTH AND DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH

1600 S 67236

Reg. Dist. No. 216

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Montgomery
   City or town: Bethesda (rural)
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: U. S. NAVAL HOSPITAL, Bethesda, Md.
   Length of mother's stay in County: 1 day
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: District of Columbia
   County:
   City or town: Washington
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: 1214 12th Street, Northwest
   (If RURAL give LOCATION)

3. Name of child: Baby Boy WELSH

4. Date of birth: 2 August 19 47 Hour: 3:03 P M.

5. Sex: Male

6. Twin or triplet: no

7. No. of weeks pregnancy: 36

FATHER OF CHILD

8. Full name: Charles Robert WELSH

9. Color: White

10. Age at time of this birth: 23 yrs.

11. Usual occupation: U.S. Marine Corps

MOTHER OF CHILD

12. Full maiden name: Eleanor Lee ANDREWS

13. Color: White

14. Age at time of this birth: 18 yrs.

15. Usual occupation: Housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
(b) How many other children were born alive but are now dead? 0 (c) How many other children were *born* dead? 0

17. Did child die before labor? no During labor? no

18. Pregnancy, complications of: no

19. Labor: (a) Complications of: - Frank breech - rapid labor (b) Induced? no

20. (a) Was there an operation for delivery? no (Yes or No)
(b) State all operations, if any:
(c) Did child die before operation? —
During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
(a) Fetal causes: Hemorrhage, subarachnoid
(b) Maternal causes: —

22. I certify to the birth of this child who was born dead* on the date and hour above stated.
Signature: PAUL PETERSON, Capt. (MC) USN
(Specify if M. D., midwife, or other)
Address: U. S. NAVAL HOSPITAL, Bethesda, Md.

23. (a) Burial (Burial, cremation or removal) (b) Date thereof 8 5 47 (month) (day) (year)
(c) Cemetery or crematory: Arlington National

24. (a) Funeral director: W. W. Chambers Co. M.R.
(b) Address: 1400 Chapin St., NW, Wash., D.C.

25. (a) 8/6/47 (Date rec'd by registrar) (b) Mary Charlotte Smith (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
Health Officer, per

Child lived 13 hours 22 minutes

V. S. A10

* See Instruction C on stub.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

67237

CERTIFICATE OF DEATH

Reg. Diat. No. 714

1. PLACE OF DEATH:

County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9908 Rogart Road.

(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Lillian Wenz

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or ~~wife~~ Henry Wenz

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1880

8. AGE:

Years	Months	Days	If less than one day
66	10	21	..... hrs. ..... min.

9. Birthplace Washington. D.C.

(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER

12. Name Jacob Frech

13. Birthplace Germany

MOTHER

14. Maiden name Elizebeth Wenz

15. Birthplace Germany

16. Informant Walter Frech

Address 4625 5th St N.W.

17. Burial - Removal Date thereof 8/9/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Lutheran

Location Queens County, Long Island, New York

18. Funeral director The S.H. Hines Co.

Address 2901 14th St N.W. Washington

19. Aug 8 1947 Josephine Schaffe Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1947, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to August 7 1947

and that I last saw her alive on August 7 1947

	DURATION
Immediate cause of death: Acute cardiac failure	30 min.
Due to: Dissecting Aneurysm of the descending Aorta	80 min.
Due to:	
Other conditions: Coronary Heart Disease	10 yrs.
Generalized Arteriosclerosis	20 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William Robert Perkins Jr. M.D.

M. D. or other

Address 1463 Rhode Island Ave. N.W. Washington, D.C. Date signed August 8, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and forcibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67238

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yr

Hospital, Institution, or street address where death occurred: 4004 East-West Highway

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Mtgmy

City or town: East - West Hwy - Chevy Chase Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: ALICE OLMSTED WHITE

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles Allen White

6.(c) If alive, give age: Dec. years

7. Birth date of deceased (mo., day, yr.): July 7, 1865

8. AGE: Years	Months	Days	If less than one day
82	0	24	....hrs. ....min.

9. Birthplace: Tarrytown, New York (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: none

FATHER — 12. Name: Charles Olmsted, Sr.

FATHER — 13. Birthplace: Tarrytown, N. Y.

MOTHER — 14. Maiden name: Racheal S. Baker

MOTHER — 15. Birthplace: Tarrytown, N. Y.

16. Informant: Allen O. White

Address: 4004 East-West Hgwy. Chevy Chase

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/3/47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Wellsely, Massachusetts

18. Funeral director: Wm. Reuben Rumpf

Address: Bethesda, Maryland

19. 8/2 19 47 (Date rec'd by registrar) Wm E Gabbett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 19 47, at 7:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April - 47 19, to — 19

and that I last saw her alive on 1 August, 19 47

Immediate cause of death	DURATION
Arterial thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: Wm Rob Bet Baker M. D. or other

Address: 1861 Wyoming Ave Washington D.C. Date signed 1 Aug 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

67239

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 124-b

CERTIFICATE OF DEATH

Reg. Dist. No. 216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County MONTGOMERY
City or town 3 DUVALL DRIVE, WESTMORELAND HILLS (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MO'S.
Hospital, institution, or street address where death occurred: SAME AS ABOVE
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County MONT.
City or town Westmoreland Hills (If outside city or town limits, write RURAL and give nearest town)
Street No. 3 DUVALL DRIVE (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM CHARLES WHITE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife MARY CAMERON WHITE
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) SEPT. 3. RD 1874

8. AGE: Years	Months	Days	If less than one day
72	11	7	..... hrs. ..... min.

9. Birthplace CANADA (Town, county, and state)
10. Usual occupation PHYSICIAN
11. Industry or business

FATHER
12. Name JAMES WHITE
13. Birthplace CANADA

MOTHER
14. Maiden name DOROTHY J. MACLEOD
15. Birthplace CANADA

16. Informant MR. HUGH T. NICOLSON
Address 3 DUVALL DRIVE, MD.

17. CREMATION (Burial, cremation, or removal. Which?) Date thereof AUG. 12 - 1947 (month) (day) (year)
Cemetery or crematory CEDAR HILL
Location MARYLAND
18. Funeral director Joseph F. Binchs Son
Address 3634 M St. N.W. Wash. DC
19. 8/10 19 47 Mrs E Forbes (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 AUGUST 19 47 at 4:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 20 19 46, to 10 AUGUST 19 47 and that I last saw h.. l.m. alive on 8 AUGUST 19 47

Immediate cause of death	DURATION
CEREBRAL VASCULAR ACCIDENT	
Due to CEREBRAL ARTERIOSCLEROSIS	
Due to	
Due to	
Other conditions ARTERIOSCLEROTIC HEART DISEASE; HEPATIC CIRRHOSIS	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W Decker, M.D. M. D. or other
Address 1725-N ST. N.W. Date signed 10 Aug. 1947

07240

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred: 7712 Wisconsin Avenue
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7712 Wisconsin Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ADA AILES WILSON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hugh L. Wilson
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 7, 1871

8. AGE: Years	Months	Days	If less than one day
75	10	3	hrs. min.

9. Birthplace: Sidney, Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: Hezekiah S. Ailes
13. Birthplace: Salem, W. Virginia

MOTHER
14. Maiden name: Jane Elliott
15. Birthplace: Anna, Chio

16. Informant: Mrs. L. W. Snyder (daughter)
Address: Mt. Prospect, Illinois

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Suitland, Maryland

18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland

19. Aug. 11 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-10 1947, at 7:13 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1 1946, to 8-10 1947
and that I last saw her alive on 8-10 1947

Immediate cause of death	DURATION
Bronchopneumonia	1 day
Due to Chronic Arthritis	15 yrs.
Due to Generalized Arteriosclerosis	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

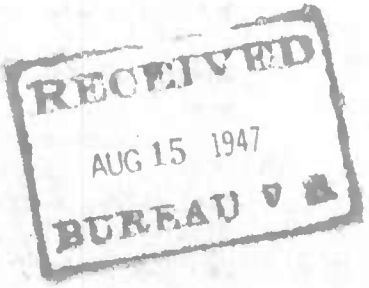
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hill Carter, M.D. M. D. or other
Address: 1835 Eye St NW Date signed: 8-10-47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
AUG 15 1947
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

67241

CERTIFICATE OF DEATH

Reg. Dist. No. 214

MARGIN RESERVED FOR BINDING

The correct age (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I)

VS A15 9-45-15

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County Frederick
City or town Winchester
(If outside city or town limits, write RURAL and give nearest town)
Street No. 552 N. Loudoun St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Julian Randolph Wisecarver

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Louise Simpson

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) May 2 1914

8. AGE: Years	Months	Days	If less than one day ... hrs. ... min.
28			

9. Birthplace Frederick County
(Town, county, and state)

10. Usual occupation Trucking

11. Industry or business

FATHER
12. Name Randolph Wisecarver
13. Birthplace Stephens City Va.

MOTHER
14. Maiden name Minnie Lay
15. Birthplace Stephens City Va.

16. Informant Randolph Wisecarver
Address Va.

17. Removal Date thereof Aug 6 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Winchester Virginia

18. Funeral director Glenn E. Pumphrey
Address Silver Spring, Md

19. Aug 6 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

Pronounced

20. DATE OF DEATH August 6 1947, at 3:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death — CORONARY HEART DISEASE Acute — DURATION

Due to Deputy Medical
Due to

Other conditions — Coroners Case
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE DeWitt E. DeLawter M.D. Asst. D.M.E.
M. D. or other
Address 4828 Chevy Chase Dr Chevy Chase 15, Md. Date signed 8/6/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

67156

CERTIFICATE OF DEATH

Reg. Dist. No. 218

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montg Co,
City or town: Boyds, Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 48yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Boyds
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clifford Welty Wright

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dora C Wright
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): May 29th 1899

8. AGE: Years	Months	Days	If less than one day
1899 48	2	29	hrs. min.

9. Birthplace: Boyds, Md,
(Town, county, and state)

10. Usual occupation: Laborer
11. Industry or business: " "

FATHER
12. Name: Charles F, Wright
13. Birthplace: Va,

MOTHER
14. Maiden name: Lula Wright
15. Birthplace: Va,

16. Informant: Claud C Wright
Address: Boyds. Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/20/47 (month) (day) (year)
Cemetery or crematory: Clarksburg Cemetery
Location: Clarksburg. Md,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg Md,

19. Aug 19 1947 (Date rec'd by registrar) Rhoda F Poole Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 18th 1947, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1946, to Aug 17 1947
and that I last saw him alive on Aug 17 1947

Immediate cause of death	DURATION
Carcinoma of Colon	
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W Ming Shirley M.D.
M. D. or other
Address: Gaithersburg Date signed Aug 19 1947